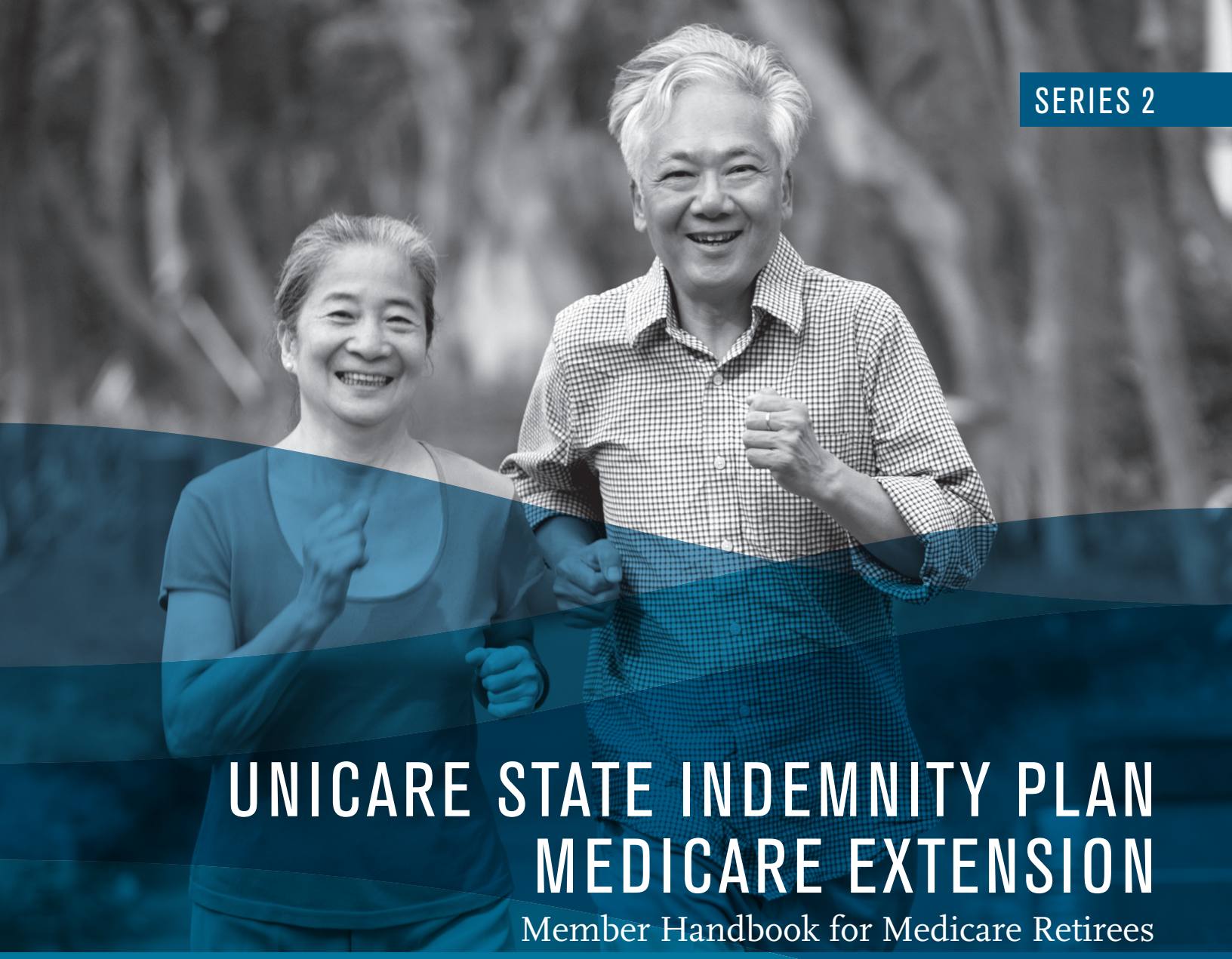

SERIES 2

UNICARE STATE INDEMNITY PLAN MEDICARE EXTENSION

Member Handbook for Medicare Retirees

Effective July 1, 2014

UniCare®

Commonwealth of Massachusetts
Group Insurance Commission

UNICARE STATE INDEMNITY PLAN
MEDICARE EXTENSION
MEMBER HANDBOOK

For Medicare retirees
Effective July 1, 2014

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Contact Information[1]

Medical Benefits

UniCare State Indemnity Plan
P.O. Box 9016
Andover, MA 01810-0916
(800) 442-9300 (toll free)
TDD: (800) 322-9161
www.unicarestateplan.com

Prescription Drug Benefits

CVS Caremark
(877) 876-7214 (toll free)
TDD: (800) 238-0756
www.caremark.com

Mental Health, Substance Abuse and Enrollee Assistance Program Benefits

Beacon Health Strategies
(855) 750-8980 (toll free)
TDD: (866) 727-9441
www.beaconhs.com/gic

1 Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

PART 1

MEDICAL PLAN

Description of Benefits

Welcome to UniCare State Indemnity Plan/Medicare Extension

This handbook is a guide to benefits for you and your Medicare dependents covered under the UniCare State Indemnity Plan/Medicare Extension. These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state, municipal and other governmental entities' employees and retirees. This Plan is funded by the Commonwealth of Massachusetts and administered by UniCare.

UniCare provides administrative services for the UniCare State Indemnity Plan/Medicare Extension – including claims processing, customer service, utilization management and medical case management – at its Andover Service Center in Andover, Massachusetts. UniCare is not the fiduciary or the insurer of the Medicare Extension Plan.

This handbook is not a description of your Medicare benefits. For more information about Medicare, read the "Medicare & You" handbook, produced by Medicare and available from your local Social Security office.

Throughout this handbook, the UniCare State Indemnity Plan/Medicare Extension is referred to either by its full name, as the "UniCare State Indemnity Plan," as the "Medicare Extension Plan" or as the "Plan." The Group Insurance Commission is referred to either by its full name or as the "GIC." In addition, the term "you" used in this handbook also includes your covered dependents.

To fully understand your benefits, please read this handbook carefully.

How This Handbook Is Organized

Descriptions of the benefits available to you and any dependents covered by this Plan are provided in the following three parts of this handbook:

Part 1: Medical Plan

This part of the handbook, which begins on page 9, describes the benefits available in the Medicare Extension Plan for medical services, treatment and supplies. These benefits are administered by **UniCare**.

Part 2: Prescription Drug Plan

This part of the handbook describes the prescription drug benefits, which are administered by **CVS Caremark**. See pages 79-91.

Part 3: Mental Health, Substance Abuse and EAP Benefits

This part of the handbook describes the mental health, substance abuse and Enrollee Assistance Program (EAP) benefits for the Medicare Extension Plan, which are administered by **Beacon Health Strategies**. See pages 93-114.

If you have questions about any of your benefits, please see the contact information on page 7.

About Your Medical Plan

The UniCare State Indemnity Plan/Medicare Extension supplements your Medicare coverage, thus providing you with comprehensive coverage throughout the world for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. You can get services from any provider, anywhere in the world. However, keep in mind that benefits differ depending on the service and the provider, and that not all services are covered by the Medicare Extension Plan.

This handbook provides information on two different plan designs:

1. **The Medicare Extension Plan *with* CIC** (comprehensive insurance coverage) is a comprehensive plan that provides benefits for most services at 100% coverage after the applicable copay and/or deductible are paid.
2. **The Medicare Extension Plan *without* CIC** is a less comprehensive plan that provides benefits for many services at 80% coverage after the applicable copay and/or deductible are paid.

How Medicare and the UniCare State Indemnity Plan/Medicare Extension Work Together

Medicare Part A provides benefits for hospital services; Medicare Part B provides benefits for physician and other health care provider services. The benefits provided by Medicare are based on established allowed charges for covered services. The UniCare State Indemnity Plan/Medicare Extension will consider charges for payment that are covered but not paid by Medicare, including the Part A inpatient hospital deductible and coinsurance and Part B deductible and coinsurance.

The Medicare Extension plan provides coverage for some services that are not covered by Medicare, such as immunizations and hearing aids. There are also some services that Medicare covers but Medicare Extension does not. See the “Excluded Services” and “Limited Services” sections to find out which services have limited or no coverage.

The benefits for an enrollee or his/her dependents covered by the Medicare Extension Plan and enrolled in Medicare are determined as follows:

1. Expenses payable by the Medicare Extension Plan are considered for payment only to the extent that they are covered by the Medicare Extension Plan and/or Medicare.
2. In calculating benefits for expenses incurred, the total amount of those expenses is first reduced by the amount of the actual Medicare benefits paid for those expenses, if any.
3. Medicare Extension Plan benefits are then applied to any remaining balance of those expenses.

Types of Medical Providers

This handbook talks about many different providers of medical care and services. Here's a brief look at what to know about the different kinds of providers.

Primary Care Providers (PCPs)

We strongly encourage all UniCare members to choose a **primary care provider**, or **PCP**. Having a PCP means working with a provider who is familiar with you and your health care needs. Your PCP can help you understand and coordinate care you get from other providers, such as specialists, who may not know you as well.

A PCP can be a nurse practitioner, physician assistant or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

Specialists (Specialty Care Physicians)

As a UniCare member, you don't need a referral to see a specialist.

Hospitals

As a UniCare member, you can use any hospital at the same level of coverage. If you get care outside of Massachusetts, be sure to use hospitals that accept Medicare payment so you don't get billed for charges above the Plan's allowed amount.

Preferred Vendors

Preferred vendors are providers who have contracted with Medicare or UniCare for certain services. When you get these services from a preferred vendor, they are covered at 100%. If you use non-preferred vendors, you'll owe 20% coinsurance and, outside of Massachusetts, you may be billed for charges above the Plan's allowed amount.

- Durable medical equipment (DME)
- Home health care
- Home infusion therapy
- Medical/diabetic supplies

How to Find the Providers You're Looking For

💻 Go to www.unicarestateplan.com > Find a Doctor to find the different providers described above, including:

- Providers in Massachusetts
- Preferred vendors
- Providers in the UniCare network

You can also call UniCare Customer Service at (800) 442-9300 for assistance.

How to Use Your Plan Wisely

Be sure to look over this section to learn what you can do to get the highest level of benefits for your medical care.

When to Notify UniCare about Medical Services

You must notify UniCare about any hospital admissions and certain outpatient services. Your benefit may be reduced by up to $500 if you don't contact UniCare within the specified amount of time. This requirement is waived if you are outside the continental United States (the contiguous 48 states).

In this handbook, the **telephone symbol** ☎ identifies the services you need to tell UniCare about. For a complete list of notification requirements, see the "Managed Care Program" section (pages 25-29).

Use Medicare Contract Suppliers or Preferred Vendors

Services from Medicare contract suppliers (when available) or UniCare preferred vendors are covered at 100% versus 80% for non-preferred vendors.

Keep Your UniCare Card at Hand

Keep your **UniCare ID card** and your **Medicare card** with you at all times, and always show them when you get medical care. That way, the provider can confirm your eligibility for benefits (page 16).

Information and Resources Online at www.unicarestateplan.com

For your convenience, you can access a broad range of plan-related and general health care information as well as helpful tools on our website: www.unicarestateplan.com.

The **computer symbol** 💻 that you see throughout this handbook indicates that information on the highlighted topic is available on our website. Our comprehensive Web resources give you the ability to:

- **Find health and wellness information** – Take our health assessment to find out how healthy you are and get customized suggestions to improve your health. Check out our *Step Into Wellness* program for information on a variety of topics, and read our monthly *eHouseCall* newsletter for health tips. You can also check our guidelines on preventive care, get patient safety information and more.
- **Get information on initiatives and resources that promote health care quality.** Learn about efforts to help hospitals reduce preventable medical errors. You'll also find resources to help you select a hospital based on a comparison of quality and cost, and more.
- **Locate UniCare preferred vendors.**
- Get convenient, secure access to **information about your claims**.
- Check out the Plan's **discounts on health-related products and services** available through the Special Offers program.
- **Email UniCare or order plan materials**, such as ID cards and handbooks.
- **View plan documents**, including this handbook and other plan information.

MedCall 24/7 Nurse Information Line

The MedCall® 24/7 Nurse Information Line provides toll-free access to extensive health information, any time of the day or night. MedCall is always available to you as an educational resource. If you have specific issues about your health or about treatment you're getting, you should always consult your doctor.

When you call MedCall, you'll speak with registered nurses who can discuss your concerns, address your questions about procedures or symptoms, and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. MedCall also serves as a referral source for local, state and national self-help agencies.

To speak with a nurse, call MedCall toll free at (800) 424-8814. You will need to provide the following plan-specific code: 1002. You can also access MedCall's library of more than 400 audio tapes to get automated information over the phone on many health-related topics.

💻 To view the list of available audio tapes, visit www.unicarestateplan.com.

Important Plan Information

Overview

This section gives you important information about the Medicare Extension Plan, including:

- The Andover Service Center and how its staff can help you
- The process for ordering new ID cards when needed
- How to access a language interpreter when speaking with a customer service representative at the Andover Service Center
- The GIC's Notice of Privacy Practices
- Contact information when you have questions about your medical plan, your prescription drug plan or your mental health, substance abuse and EAP benefits

The Andover Service Center

The Andover Service Center is where UniCare administers services; processes claims; and provides customer service, utilization management and medical case management for the medical component of the Plan. Representatives are available at (800) 442-9300 Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. (Eastern time) to answer questions you and your family may have about your medical coverage.

💻 You can also access claims information 24 hours a day, seven days a week from our automated telephone line, or from www.unicarestateplan.com.

When you call the Andover Service Center, you will speak with a customer service representative or a nurse reviewer, depending on the nature of your call.

Customer Service Representatives

Customer service representatives are benefits specialists who can answer questions about:

- Claim status
- Notification requirements
- Covered services
- Preferred vendors and Medicare contract suppliers
- Plan benefits
- Resources on our website: www.unicarestateplan.com

Nurse Reviewers

Nurse reviewers are registered nurses who can help you coordinate your Plan benefits based on your health care needs. The nurse reviewer can:

- Provide information about the Managed Care Program, including Utilization Management, Medical Case Management, and Quality Centers and Designated Hospitals for Transplants
- Answer questions about the Plan's coverage for hospital stays and certain outpatient benefits
- Speak with you and your physician about covered and non-covered services to help you obtain care and coverage in the most appropriate health care setting, and let you know what services are covered
- Assist you with optimizing benefits for covered services after you are discharged from the hospital

Your ID Card

When you are enrolled in the Plan, you will get a UniCare ID card. When you need health care services, tell your physician, hospital or other provider that you are a member of Medicare **and** the Medicare Extension plan. Show your provider both your Medicare card and your UniCare ID card.

Your ID card contains useful information about your benefits and important telephone numbers you and your doctors may need.

💻 If you lose your ID card or need additional cards, you can order them from www.unicarestateplan.com. You can also call the Andover Service Center at (800) 442-9300.

Interpreting and Translating Services

If you need a language interpreter when you contact the Andover Service Center, a customer service representative will access a language line and connect you with an interpreter who will translate your conversation with the representative.

If you are deaf or hard of hearing and have a TDD machine, you can contact UniCare by calling our telecommunications device for the deaf (TDD) line at (800) 322-9161 or (978) 474-5163.

Notice of Privacy Practices

The GIC's Notice of Privacy Practices appears in Appendix A.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The GIC keeps the health and financial information of current and former members private, as required by law. This notice also explains your rights as well as the GIC's legal duties and privacy practices. The GIC's policies comply with the Health Insurance Portability and Accountability Act (HIPAA), the federal standard for the protection of personal health information.

Understanding Costs

Overview

This section talks about the costs associated with medical services that the Plan covers. Topics in this section include:

- Member costs that are your responsibility to pay: **calendar year deductible**, **copays** and **coinsurance**
- The **out-of-pocket limit** on your member costs
- How UniCare reimburses providers
- What **balance billing** is and how to avoid it

Your Member Costs

There are three types of member costs that are your responsibility to pay for the medical care you and your family get. These costs, which are separate costs that apply in different situations and are for different services, are:

- Calendar year deductible (page 18)
- Copays or copayments (pages 18-19)
- Coinsurance (page 19)

How Member Costs Work

Because you are in the Medicare Extension plan, your claims go first to Medicare. Medicare pays its portion of a bill, and the claim balance is sent to UniCare. UniCare subtracts any member costs you owe from the amount we pay the provider. That provider will then send you a bill for the amount of your member costs.

We deduct member costs in the order that your claims arrive at UniCare (which may not be in the same order that you got the medical services). You'll get an Explanation of Benefits (EOB) that lists which providers you will owe payment to.

A copay, if there is one, is always subtracted first. Then, the calendar year deductible is subtracted, and finally the coinsurance.

About the Calendar Year Deductible

The **calendar year deductible** is a set amount you pay toward medical services each year before the Plan begins paying benefits for those services. The calendar year deductible begins on January 1 each year. The deductible amounts you must satisfy are shown below.

Table 1. Calendar Year Deductible Amounts

$35	With CIC (Comprehensive Insurance Coverage)
$100	Without CIC (Non-Comprehensive Insurance Coverage)

This deductible applies to some services, but not all. For example, the deductible applies to office visits, physical therapy and outpatient hospital services, but it doesn't apply to preventive care visits, laboratory tests and X-rays. To find out whether the deductible applies to a particular medical service, see the "Benefit Highlights" section.

> **Example** – You have coverage with CIC. In January, you go to the doctor for a medical problem. You will owe your deductible on the balance of that bill that remains after Medicare's payment.

Deductible Carryover

If you pay any of your calendar year deductible for services you get during the last three months of the calendar year (October, November and December), that amount will be applied to your deductible in the following year. You must have had continuous coverage in the Plan since you had those services.

About Copays

A **copay** (or **copayment**) is a set amount you pay when you get certain medical services. For example, you pay a copay when you get an eye exam, or when you go to the emergency room. The dollar amount of your copay varies depending on what service you're getting. Table 2 lists the copays you will owe for certain types of medical services.

Table 2. Copays for Medical Services

Type of Service	Coverage without CIC (Non-Comprehensive Insurance Coverage)	Coverage with CIC (Comprehensive Insurance Coverage)
Office Visits	None	None
Routine Eye Exams	$10	$10
Emergency Room	$25 (waived if admitted)	$25 (waived if admitted)
Inpatient Hospital Care	$100 per quarter	$50 per quarter

Copays can work in two ways:

- *Quarterly copays* – You pay quarterly copays only once in a calendar quarter[1], no matter how many times you get that service during the quarter. The copay for inpatient hospital services is a quarterly copay.
- *Per-visit copays* – These are copays you pay every time you have a particular service. Emergency room visits are an example of per-visit copays.

Inpatient Hospital Quarterly Copay

The inpatient hospital copay is a per-person quarterly[1] copay. Each time you or a covered dependent is admitted to a hospital, you will owe this copay. However, once you pay this copay during a calendar year quarter, you won't have to pay it again for this person during the same quarter. As is true of all member costs, this copay is applied to any balances that remain after Medicare considers your claims.

> **Example** – You have coverage with CIC. You are admitted to a hospital in January and stay overnight, so you owe this copay on the balance that remains after Medicare's payment. If you are readmitted to a hospital in March, you won't owe another copay, because March is within the same calendar year quarter. But if you are readmitted to a hospital in May, you will have to pay the copay again.

If you are readmitted to the hospital within 30 days, you won't owe another inpatient hospital copay, as long as both hospital admissions are in the same calendar year. This is true even if the two admissions occur in different quarters.

About Coinsurance

Coinsurance is your share of the cost of a covered service when the service isn't covered at 100%. For example, if the Plan pays 80% of the allowed amount for a service, you are responsible for paying the other 20%. As is true of all member costs, coinsurance is applied to any balances that remain after Medicare considers your claims. To find out which benefits have coinsurance, see the "Benefit Highlights" section.

About the Out-of-Pocket Limit

If you have CIC coverage

To protect you from large medical expenses, the Medicare Extension Plan with CIC limits how much coinsurance you could pay each year. Once you reach this **out-of-pocket limit**, the Plan pays 100% of the allowed amount for the rest of the year.

The out-of-pocket limit is $500 for each covered person.

Deductibles, copays, certain coinsurance amounts, any amounts paid over the allowed amount, and charges for non-covered services don't count toward the out-of-pocket limit. To find out about a particular service, see the "Benefit Highlights" section.

If you don't have CIC coverage

There is no out-of-pocket limit if you don't have CIC coverage.

1 Calendar year quarters are: January/February/March, April/May/June, July/August/September and October/November/December.

About Provider Reimbursement

Allowed Amounts

UniCare reimburses a provider for a service based on the **allowed amount** for that service. The allowed amount is either the amount Medicare allows for a service or the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. UniCare uses a variety of methods to determine allowed amounts, and they are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges. They are the maximum amounts that the Plan pays for covered health care services.

How UniCare Reimburses Providers

The Plan reimburses providers on a fee-for-service basis. The Plan does not withhold portions of benefit payments from providers, nor does it offer incentive payments to providers related to controlling the utilization of services. Explanations of provider payments are detailed in your Explanations of Benefits (EOBs). In the Plan, providers are not prohibited from discussing the nature of their compensation with you.

How Allowed Amounts and Balance Billing Work

Balance Billing (Charges over the Allowed Amount)

The allowed amount for a given service may not be the same as what a provider actually charges. When a provider asks you to pay for charges above the allowed amount (that is, above the amount paid by insurance), it is called **balance billing**.

The Plan does not cover balance bills, nor are balance bills included in your out-of-pocket limit. By law, Massachusetts providers aren't allowed to balance bill you. However, providers in other states may do so.

When You Get Care in Massachusetts

Massachusetts providers are not allowed to balance bill you for charges over the allowed amount (Massachusetts General Law, Chapter 32A: Section 20). If you get a balance bill from a Massachusetts provider, contact the Andover Service Center to help you resolve this issue.

If You Get Care Outside of Massachusetts

Providers outside of Massachusetts are free to balance bill you for the difference between the Plan's allowed amount and what the provider charged. Since the Plan doesn't cover balance bills, payment is your responsibility. To minimize your risk of being balance billed, we recommend always using providers who accept Medicare.

About Preferred Vendors

Some providers of certain services and supplies have contracts with Medicare or UniCare, and they are covered at a higher benefit than non-contracted providers. These **preferred vendors** provide the following services:

- Durable medical equipment (DME)
- Home health care
- Home infusion therapy
- Medical/diabetic supplies

If you use non-preferred vendors, you will owe coinsurance. Outside of Massachusetts, you may also be balance billed. Since the Plan doesn't cover balance bills, payment is your responsibility.

For Services that Medicare Covers

For any of these services that Medicare covers, the preferred vendors are those providers that have a contract with Medicare (called **Medicare contract suppliers**). You must use a Medicare contract supplier, if one is available to you, to get the most complete coverage.

💻 Go to www.medicare.gov/supplier for a list of Medicare contract suppliers.

Sometimes, there may not be a Medicare contract supplier near you, even though Medicare covers the service. In that case, use a UniCare preferred vendor to get the highest level of coverage. For a list of UniCare preferred vendors, see Appendix F.

For Services Not Covered by Medicare

For services that the Plan covers but Medicare doesn't, the preferred vendors are those that have a contract with UniCare. For these services, always use a UniCare preferred vendor to get the highest level of coverage. For a list of UniCare preferred vendors, see Appendix F.

Your Claims

Overview

This section provides information on how to submit a claim, how your benefits are covered when you have coverage under more than one health plan, how to view your claims online, the Plan's claim review process, your appeal rights under the Plan, and other important information relating to your claims.

How to Submit a Claim

Before the Plan can process your claims, your claims must first be submitted to Medicare for consideration. Most hospitals, physicians or other health care providers will submit claims to Medicare for you. You will receive an Explanation of Medicare Benefits (EOMB) that explains what Medicare paid and if there are balances remaining.

Once Medicare processes your claims, any remaining balance is automatically sent to the Andover Service Center, where benefits under the Medicare Extension Plan are determined. This process is called **Medicare crossover**. You are not responsible for paying any balances until the Medicare crossover process is completed. At that time you will receive an Explanation of Benefits (EOB) from the UniCare Medicare Extension Plan.

If the situation arises where you need to submit your own claim, you must first submit the claim to Medicare. You must then submit written proof of the claim to the Andover Service Center that includes:

- Medicare EOMB
- Diagnosis
- Date of service
- Amount of charge
- Name, address and type of provider
- Provider tax ID number, if known
- Name of enrollee
- Enrollee's ID number
- Name of patient
- Description of each service or purchase
- Other insurance information, if applicable
- Accident information, if applicable
- Proof of payment, if applicable

If the proof of payment you receive from a provider contains information in a foreign language, please provide the Plan with a translation of this information, if possible.

The Plan's claim form may be used to submit written proof of a claim. Original bills or paid receipts from providers will also be accepted as long as the information described above is included.

💻 You can print or request a claim form from www.unicarestateplan.com. Or call the Andover Service Center at (800) 442-9300 for assistance.

Claims for prescription drug or mental health, substance abuse or EAP benefits *– Claims for these services must be submitted directly to the administrator of those services. See pages 79-91 (prescription drug program) or pages 93-114 (mental health, substance abuse and EAP).*

Filing Deadline

Written proof of a claim must be submitted to the Plan within two years from the date of service. Claims submitted after two years will be accepted for review if it is shown that the person submitting the claim was mentally or physically incapable of providing written proof of the claim in the required time frame.

Claims Review Process

The Plan routinely reviews submitted claims to evaluate the accuracy of billing information about services performed. The Plan may request written documentation such as operative notes, procedure notes, office notes, pathology reports and X-ray reports from your provider. In cases of suspected claim abuse or fraud, the Plan may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician chosen by the Plan. This examination must be approved by the Executive Director of the GIC, and will be performed at no expense to you.

Restrictions on Legal Action

No legal action or suit to recover benefits for charges incurred while covered under the Plan may be started before 60 days after written proof of a claim has been furnished. Further, no such action or suit may be brought more than three years after the time such proof has been furnished. If either time limit is less than permitted by state law in the state you lived in when the alleged loss occurred, the limit is extended to be consistent with that state law.

Right of Reimbursement

The Plan will have a lien on any recovery made by you or your dependents covered under this Plan for an injury or disease to the extent that you or your dependents has received benefits for such injury or disease from the Plan. That lien applies to any recovery made by you or your dependents from any person or organization that was responsible for causing such injury or disease, or from their insurers. Neither you nor your dependents will be required to reimburse the Plan for more than the amount you or your dependents recover for such injury or disease.

You or your dependents must execute and deliver such documents as may be required, and do whatever is necessary to help the Plan in its attempts to recover benefits it paid on behalf of you or your dependents.

Claims Inquiry

If you have questions about your claims, contact the Andover Service Center in one of the following ways to request a review of your claim:

- Call us at (800) 442-9300
- Write to the UniCare State Indemnity Plan, Claims Department, P.O. Box 9016, Andover, MA 01810-0916
- 💻 Email us from www.unicarestateplan.com > Contact Us

If you have additional information, please include it with your letter. You will be notified of the result of the investigation and of the final determination.

24-Hour Access to Claims Information

You can also check the status of your claims 24 hours a day, seven days a week in the following two ways:

- Call us at (800) 442-9300 and select the option to access our automated information line.
- 💻 Visit www.unicarestateplan.com. Register by creating a user ID and password to protect the privacy of your information. Dependents age 18 or older can access their individual claims information by establishing their own user IDs and passwords.

Appeal Rights

You have the right to appeal a benefit determination made by the Plan within 60 days of the notification of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation (at your own expense) that you or your health care provider believes supports your position.

The Plan will conduct a review of the submitted documentation, and a decision will be made within 30 days after receipt of your written request. The results of the appeal review will be sent to you in writing. The letter will contain the specific reasons for the Plan's decision and, if applicable, instructions as to any additional appeal procedures that may be available.

Appeals relating to the Managed Care Review program (inpatient hospital admissions, durable medical equipment, home infusion therapy and home health care) should be directed to:

UniCare State Indemnity Plan
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

All other appeals should be directed to:

UniCare State Indemnity Plan
Appeals Review
P.O. Box 2075
Andover, MA 01810-0037

Appeals for mental health, substance abuse or EAP services *– Appeals for these services must be filed with Beacon Health Strategies, the administrator of those services.* *See pages 93-114.*

Request and Release of Medical Information

The GIC's policies for releasing and requesting medical information comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, see the GIC's Notice of Privacy Practices in Appendix A.

Managed Care Program

Overview

UniCare's Managed Care Program, located in the Andover Service Center, includes the following components:

- Notification Requirements
- Utilization Management Review Program
- Medical Case Management
- Quality Centers and Designated Hospitals for Transplants

The Managed Care Program reviews clinical information ("clinical criteria") for certain health care services to determine whether the services are eligible for benefits. This process, called **utilization management**, is a standard component of most health plans. It helps ensure that benefits are paid appropriately for services that meet the Plan's definition of medical necessity. Utilization management helps control costs while preserving the ability of the GIC to offer the benefits of an indemnity plan to members.

The Managed Care Program also reviews the benefits available to you from Medicare, and helps coordinate coverage.

The clinical criteria used for these reviews have been developed with input from actively practicing physicians, and are developed in accordance with the standards adopted by the national accreditation organizations. They are updated at least three times a year, or more often as new treatments, applications and technologies are adopted as generally-accepted professional medical practice.

Managed Care staff includes nurse reviewers and physician advisors. To determine eligibility for benefits, nurse reviewers speak with your doctors, hospital staff, and/or other health care providers to review your clinical situation and circumstances. In addition, your physician will be offered the opportunity to speak with a physician advisor in Managed Care to discuss the proposed treatment and/or the setting in which it will be provided. Managed Care staff will inform you about what services will be eligible for benefits.

When to Notify UniCare about Upcoming Medical Care

The list of notification requirements on page 26 lets you know when you must notify the Andover Service Center about a treatment, service or procedure. Managed Care staff will review your case to determine if the care is eligible for benefits under the Plan. This process reduces your risk of having to pay for non-covered services.

This review process begins when you, or someone acting for you, notifies the Andover Service Center that:

- You or your dependent will be or has been admitted to the hospital; or
- A provider (either in Massachusetts or elsewhere) has recommended one of the listed procedures or services.

Important: If you fail to notify the Andover Service Center within the required time frame (specified in the list on page 26), your benefits may be reduced by as much as $500.

💻 You can also find the notification requirements at www.unicarestateplan.com.

Information You Must Provide When You Call

When you call the Andover Service Center, please have the following information available:

- The procedure or service being performed
- The hospital admission date or the start of service date
- The name, address and phone number of the admitting or referring physician, as well as the fax number, if possible
- The name, address and phone number of the facility or vendor, as well as the fax number, if possible

If you aren't sure whether a treatment, service or procedure is on this list, check with your doctor, or call the Andover Service Center at (800) 442-9300.

Important: Submitting a claim for service is not enough to meet this requirement. You must contact the Andover Service Center directly, and within the amount of time listed in the table.

Notification Requirements

You must notify the Andover Service Center within the specified amount of time for these services. Note that some of the listed procedures may be performed in a doctor's office.

Table 3. ☎ Notification Requirements

Treatment / Service	Requirements
Emergency admission	**Within 24 hours (next business day)**
Maternity admission	**Within 24 hours (next business day)**
Non-emergency admission	**At least 7 calendar days before admission** For elective inpatient treatment
Organ transplants	**At least 21 calendar days before transplant-related services begin** *Exception:* cornea transplants don't require notification
Durable medical equipment (DME)[1]	**At least 1 business day before ordering the equipment** You must notify UniCare if the purchase price exceeds $500, or if the expected rental charges will exceed $500 over the period of use. *Exception:* oxygen and oxygen equipment don't require notification
Home health care	**At least 1 business day before the services begin if Medicare is not going to cover the services** Services must be provided by: • Home health agencies[1] • Visiting nurse associations[1]
Home infusion therapy[1]	**At least 1 business day before the services begin**
Private duty nursing	**At least 1 business day before the services begin**

1 To get the highest benefit, use preferred vendors for these services. See page 16 for information about preferred vendors.

Utilization Management Review Program

Reviews for Inpatient Hospital Admissions

Initial Review for Hospital Admissions

The Plan must review all inpatient hospital admissions. You or someone acting for you must call the Andover Service Center at (800) 442-9300 at least seven days before a non-emergency admission, and within 24 hours of, or the next business day after, an emergency or maternity admission.

The purpose of this review is to let you know if the admission is eligible for benefits under the Plan. Calling the Andover Service Center reduces your risk of having to pay for non-covered services.

Medicare covers 60 days at 100% after Medicare's deductible for medically necessary hospital care that occurs within a "benefit period." Those 60 days can occur as a result of one or multiple hospitalizations.

A benefit period begins the day you are first admitted to a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 straight days. The benefit period also ends if you are in a skilled nursing facility but have not gotten skilled care in that facility for 60 straight days.

After the 60-day period, the next time you are admitted to a hospital, a new benefit period begins and your hospital and skilled care Medicare benefits are renewed. There is no limit on the number of Medicare benefit periods that you can have. If you have additional questions about your Medicare benefits, please consult the "Medicare & You" handbook or call your local Social Security office.

Depending on the benefits available to you from Medicare, a nurse reviewer will determine the need for a review of your hospitalization. The nurse reviewer may call your provider for clinical information to help with the review process.

If the nurse reviewer is unable to make a determination, your provider will be offered the opportunity to speak with a physician advisor. If the Plan determines that the admission is not eligible for benefits, the nurse reviewer will promptly notify you, your doctor and the hospital.

Continued Stay Review for Hospital Admissions

You should notify the Plan if your stay in any hospital adds up to or is near 60 days within one benefit period. When this occurs, the nurse reviewer will review the continuing hospital stay. The nurse reviewer may call your provider while you are in the hospital to determine whether a continued hospital stay is eligible for benefits under the Plan. During your continued stay, the nurse reviewer will also work with the hospital staff to facilitate planning for care that may be required after your discharge.

If the nurse reviewer is unable to make a determination about your continued hospitalization, your provider will be offered the opportunity to speak with a physician advisor. If the Plan determines that the continued stay is not eligible for benefits, the nurse reviewer will promptly notify you, your doctor and the hospital.

Reviews for Durable Medical Equipment (DME) over $500

Any durable medical equipment (DME) – other than oxygen and oxygen equipment – ordered by a physician that is expected to cost more than $500 is subject to review. The $500 cost may be the purchase price or the total rental charges.

You must notify UniCare at least one business day before the equipment is ordered from the equipment provider. A nurse reviewer may call your provider for clinical information to help determine if the equipment is eligible for benefits. Once the decision is made, UniCare will contact your provider directly, and you will be notified in writing.

If you get equipment from a preferred vendor, the authorized item will be covered at 100% of the allowed amount after the calendar year deductible. Any equipment you get from a non-preferred vendor is covered at 80% of the allowed amount (after the calendar year deductible).

Please note that if an item isn't available from a preferred vendor, although authorized, it will only be covered at 80% of the allowed amount (after the calendar year deductible).

Reviews for Home Health Care, Home Infusion Therapy and Private Duty Nursing

When a physician prescribes home infusion therapy (as described in "Plan Definitions") or other home health care services, you must notify UniCare at least one business day before services begin, if Medicare won't cover the full amount of the requested services.

A nurse reviewer may call your provider for clinical information to help determine if the services are eligible for benefits. Once the decision is made, UniCare will contact your provider directly, and you will be notified in writing.

Reconsideration After a Denial

If benefits are denied before or while health care services are being provided, either the attending physician or the member may ask for reconsideration by telephone or mail.

The Andover Service Center must get the request and all supporting information within three business days of the initial denial notification. The reconsideration will be completed within two business days after all necessary supporting documentation has been received. The decision is then communicated in writing to the member and the member's health care provider.

If the denial is upheld, the member can appeal the decision to:

UniCare State Indemnity Plan
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

Medical Case Management

A **medical case manager** is a registered nurse who can assist you and your family when you are faced with a serious medical problem such as a stroke, cancer, spinal cord injury or another condition that requires multiple medical services. Medical case managers help to establish goals that are tailored to meet your health care needs.

The medical case manager will:

- Help you and your family cope with the stress associated with an illness or injury by facilitating discussions about health care planning
- Support the coordination of services among multiple providers

- Work with the attending physician and other providers to support the member's present and future health care needs
- Provide the member with information about available resources
- Work with mental health/substance abuse benefits administrators to help coordinate services and maximize benefits, if your condition requires both medical and mental health services
- Explore alternative funding or other resources in cases where there is need but benefits under the Plan are limited
- Promote education, wellness, self-help and prevention programs to help manage chronic disease conditions
- Promote the development of a care plan to ease the transition from hospital to home

Quality Centers and Designated Hospitals for Transplants

UniCare has designated certain hospitals as Quality Centers and Designated Hospitals for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high-quality transplant care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible Plan members.

Transplants at Quality Centers and Designated Hospitals are covered at 100% after the applicable copay and deductible. Transplants at other hospitals are covered at 80% after the applicable copay and deductible. Although you have the freedom to choose any health care provider for these procedures, you can maximize your benefits when you use one of these Quality Centers or Designated Hospitals. You or someone on your behalf should notify the Plan as soon as your physician recommends a transplant evaluation.

A medical case manager is available to support the member and family before the transplant procedure and throughout the recovery period. He or she will:

- Review the member's ongoing needs
- Help to coordinate services while the member is awaiting a transplant
- Help the member and family optimize Plan benefits
- Maintain communication with the transplant team
- Facilitate transportation and housing arrangements, if needed
- Facilitate discharge planning alternatives
- Help to coordinate home care plans, if appropriate
- Explore alternative funding or other resources in cases where there is need but benefits under the Plan are limited

To contact Medical Case Management, please call UniCare Customer Service at (800) 442-9300 and ask to speak with a medical case manager.

Benefit Highlights

A Summary of Your Medical Benefits

This section contains a summary of your medical benefits under the Medicare Extension Plan after consideration by Medicare, as follows:

- What the plan pays – with CIC (comprehensive insurance coverage) and without CIC (non-comprehensive insurance coverage)
- Which member costs (deductible, coinsurance and/or copays) you are responsible for paying in connection with a service or supply (for copay and deductible amounts, see the "Understanding Costs" section)
- Any limits on the number of visits allowed or dollar amounts paid per calendar year

Important: The information contained in this section is only a summary of your medical benefits. For additional details of your medical plan benefits, see the "Description of Covered Services" section.

Book Symbol

The book symbol 🕮 next to each service listed in the Summary tables directs you to other pages that provide additional details about that service.

Telephone Symbol

The telephone symbol ☎ lets you know that, to obtain the highest benefit for this service, you must call the Andover Service Center at (800) 442-9300. If you don't do so, your benefits may be reduced by up to $500. However, you don't need to call UniCare if you are outside the continental United States (the contiguous 48 states). See the "Managed Care Program" section for more information about the notification requirements associated with these benefits.

Computer Symbol

The computer symbol 💻 indicates that information on the highlighted topic is available at www.unicarestateplan.com.

Table 4. Summary of Covered Services (after consideration by Medicare)

	Without CIC	With CIC
☎ Inpatient Hospital Services in an Acute Medical, Surgical or Rehabilitation Facility		📖 Also see pages 27, 38
Semi-Private Room, ICU, CCU and Ancillary Services	100% after the inpatient hospital quarterly copay	100% after the inpatient hospital quarterly copay
Medically Necessary Private Room	100% of the semi-private room rate after the inpatient hospital quarterly copay	100% of the semi-private room rate after the inpatient hospital quarterly copay
Inpatient Diagnostic Laboratory and Radiology Expenses	100%	100%
☎ Transplants		📖 Also see pages 29, 46
Quality Centers and Designated Hospitals for Transplants (see page 29)	100% after the inpatient hospital quarterly copay	100% after the inpatient hospital quarterly copay
Other Hospitals	80% after the inpatient hospital quarterly copay	80% after the inpatient hospital quarterly copay **Note:** The 20% coinsurance does not count toward the out-of-pocket limit
Other Inpatient Facilities		📖 Also see pages 39, 63
• **Sub-Acute Care Hospitals/Facilities** • **Transitional Care Hospitals/Facilities** • **Long-Term Care Hospitals/Facilities** • **Chronic Disease Hospitals/Facilities** • **Skilled Nursing Facilities**	**For days paid by Medicare:** Part A deductible and coinsurance up to 100 days after the calendar year deductible; then 80% for the remainder of the calendar year up to a calendar year limit of $7,500 **For days *not* paid by Medicare:** 80% up to the calendar year limit of $7,500	**For days paid by Medicare:** Part A deductible and coinsurance up to 100 days after the calendar year deductible; then 80% for the remainder of the calendar year up to a calendar year limit of $10,000 **For days *not* paid by Medicare:** 80% up to the calendar year limit of $10,000 **Note:** Whether or not Medicare pays, the 20% coinsurance does not count toward the out-of-pocket limit

For deductible and copay amounts, see the charts in the "Understanding Costs" section. All services must be medically necessary and all charges are subject to the allowed amount.

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

Table 4. Summary of Covered Services (after consideration by Medicare) *(continued)*

	Without CIC	With CIC
Emergency Room Treatment		Also see pages 27, 39
Emergency Room	100% after the emergency room copay per visit (copay waived if admitted)	100% after the emergency room copay per visit (copay waived if admitted)
Radiology		
• For an emergency (accident or sudden serious illness)	100%	100%
• Non-emergency	80%	100%
Diagnostic Laboratory Testing		
• For an emergency (accident or sudden serious illness)	100%	100%
• Non-emergency	80%	100%
Surgery		Also see pages 40, 61, 66
Inpatient or Outpatient	**In Massachusetts:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Assigned:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Unassigned:** 100% of Part B deductible and coinsurance amount	**In Massachusetts:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Assigned:** 100% of Part B deductible and coinsurance amount **Outside Massachusetts – Medicare Unassigned:** 100% of Part B deductible and coinsurance amount; then 80% of the difference between the Medicare payment and the covered charge

For deductible and copay amounts, see the charts in the "Understanding Costs" section. All services must be medically necessary and all charges are subject to the allowed amount.

Table 4. Summary of Covered Services (after consideration by Medicare) *(continued)*

	Without CIC	With CIC
Outpatient Medical Care		Also see pages 41-46
For Services at a Hospital (other than the services listed below)	100% after the calendar year deductible	100% after the calendar year deductible
Diagnostic Laboratory Testing and Radiology	80%	100%
Licensed Retail Medical Clinics at Retail Pharmacies	80% after the calendar year deductible	100% after the calendar year deductible
Physical Therapy and Occupational Therapy	80% after the calendar year deductible	**If Medicare pays:** 100% of the Part B deductible and coinsurance amount **If Medicare does *not* pay:** 80% after the calendar year deductible
Speech Therapy	80% after the calendar year deductible, up to a limit of $2,000 per calendar year	100% after the calendar year deductible, up to a limit of $2,000 per calendar year
Chemotherapy	80% after the calendar year deductible	100% after the calendar year deductible
Dialysis	100% after the calendar year deductible	100% after the calendar year deductible
Physician Services		Also see page 45
Non-Emergency Treatment at Home, Office or Outpatient Hospital	100% after the calendar year deductible	100% after the calendar year deductible
Hospital Inpatient	100%	100%
Emergency Treatment	100%	100%
Chiropractic Care or Treatment	80% after the calendar year deductible; up to a limit of 20 visits per calendar year	80% after the calendar year deductible; up to a limit of 20 visits per calendar year
Preventive Care		Also see page 57 and Appendix E
	100%	100%

For deductible and copay amounts, see the charts in the "Understanding Costs" section. All services must be medically necessary and all charges are subject to the allowed amount.

Table 4. Summary of Covered Services (after consideration by Medicare) *(continued)*

	Without CIC	With CIC
☎ Private Duty Nursing		📖 Also see pages 28, 45
Inpatient (must not duplicate services that a hospital or facility is licensed to provide)	100% after the calendar year deductible, up to a calendar year limit of $1,000. The limit includes benefits paid by Medicare, then 80%	100% after the calendar year deductible, up to a calendar year limit of $1,000. The limit includes benefits paid by Medicare, then 80%
Outpatient	80% after the calendar year deductible, up to a calendar year limit of $4,000. The limit includes benefits paid by Medicare	80% after the calendar year deductible, up to a calendar year limit of $8,000. The limit includes benefits paid by Medicare **Note:** The 20% coinsurance does not count toward the out-of-pocket limit
☎ Home Health Care		📖 Also see pages 28, 43, 61
Preferred Vendors[1]	100% after the calendar year deductible	100% after the calendar year deductible
Non-preferred Vendors	80% after the calendar year deductible	80% after the calendar year deductible
☎ Home Infusion Therapy		📖 Also see pages 28, 61
Preferred Vendors[1]	100% after the calendar year deductible	100% after the calendar year deductible
Non-preferred Vendors	80% after the calendar year deductible	80% after the calendar year deductible **Note:** The 20% coinsurance amount does not count toward the out-of-pocket limit
Hospice		📖 Also see pages 47, 61
Medicare-Certified Hospice	100% after the calendar year deductible	100% after the calendar year deductible
Bereavement Counseling	80% after the calendar year deductible, up to a limit of $1,500 per family	80% after the calendar year deductible, up to a limit of $1,500 per family **Note:** The 20% coinsurance does not count toward the out-of-pocket limit

For deductible and copay amounts, see the charts in the "Understanding Costs" section. All services must be medically necessary and all charges are subject to the allowed amount.

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

1 For a list of UniCare preferred vendors, see Appendix F.

Table 4. Summary of Covered Services (after consideration by Medicare) *(continued)*

	Without CIC	With CIC
Early Intervention Services for Children		📖 Also see pages 42. 60
Programs approved by the Department of Public Health	80% after the calendar year deductible, up to a limit of $5,200 per child per calendar year, and a lifetime limit of $15,600	80% after the calendar year deductible, up to a limit of $5,200 per child per calendar year, and a lifetime limit of $15,600 **Note:** The 20% coinsurance does not count toward the out-of-pocket limit
Ambulance		📖 Also see pages 41, 55
	100% of the first $25	100% after the calendar year deductible
☎ Durable Medical Equipment (DME)		📖 Also see pages 28, 48, 60
Preferred Vendors[1]	100% after the calendar year deductible	100% after the calendar year deductible
Non-preferred Vendors	80% after the calendar year deductible	80% after the calendar year deductible **Note:** The 20% coinsurance does not count toward the out-of-pocket limit
Hospital-Based Personal Emergency Response Systems (PERS)		📖 Also see page 48
Installation	80% after the calendar year deductible, up to a limit of $50	80% after the calendar year deductible, up to a limit of $50 **Note:** The 20% coinsurance does not count toward the out-of-pocket limit
Rental Fee	$40 per month limit	$40 per month limit

For deductible and copay amounts, see the charts in the "Understanding Costs" section. All services must be medically necessary and all charges are subject to the allowed amount.

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

1 For a list of UniCare preferred vendors, see Appendix F. To find a Medicare contracted supplier, go to www.medicare.gov/supplier. If an item isn't available from a preferred vendor and you get it elsewhere, it will be covered at 80%.

Table 4. Summary of Covered Services (after consideration by Medicare) *(continued)*

	Without CIC	With CIC
Prostheses[1]		Also see pages 45, 64
	If Medicare pays: 100% of the Medicare deductible and Medicare coinsurance **If Medicare does *not* pay:** 80%	**If Medicare pays:** 100% of the Medicare deductible and Medicare coinsurance **If Medicare does *not* pay:** 80%
Braces[2]		Also see page 41
	If Medicare pays: 100% of the Medicare deductible and Medicare coinsurance **If Medicare does *not* pay:** 80%	**If Medicare pays:** 100% of the Medicare deductible and Medicare coinsurance **If Medicare does *not* pay:** 80%
Hearing Aids		Also see page 43
Age 21 and under	100% up to a limit of $2,000 for each impaired ear every 36 months	100% up to a limit of $2,000 for each impaired ear every 36 months
Age 22 and over	100% of the first $500 (after calendar year deductible); then 80% of the next $1,500, up to a limit of $1,700 every two years	100% of the first $500 (after calendar year deductible); then 80% of the next $1,500, up to a limit of $1,700 every two years **Note:** The 20% coinsurance does not count toward the out-of-pocket limit
Eyeglasses / Contact Lenses		Also see page 56
	80%. Limited to the initial set within six months following cataract surgery	100%. Limited to the initial set within six months following cataract surgery
Routine Eye Examinations (including refraction and glaucoma testing)		Also see page 45
	100% after the routine eye exam copay. Covered once every 24 months	100% after the routine eye exam copay. Covered once every 24 months

For deductible and copay amounts, see the charts in the "Understanding Costs" section. All services must be medically necessary and all charges are subject to the allowed amount.

1 Breast prostheses are covered at 100%.

2 Orthopedic shoe with attached brace is covered at 100%.

Table 4. Summary of Covered Services (after consideration by Medicare) *(continued)*

	Without CIC	With CIC
Family Planning Services		Also see pages 43, 60
Office Visits	100%	100%
Procedures	100%	100%
Tobacco Cessation Counseling		Also see pages 46, 57, 66
	100%, up to 300 minutes per calendar year	100%, up to 300 minutes per calendar year
Fitness Club Reimbursement		Also see pages 43, 56, 60
	$100 per family per calendar year	$100 per family per calendar year
All Other Covered Medical Services		Also see pages 41-46
	80% after the calendar year deductible	80% after the calendar year deductible
Prescription Drug Plan		See pages 79-91
Benefits administered by CVS Caremark. For more information, call (877) 876-7214 (toll free).		
Mental Health, Substance Abuse and EAP Services		See pages 93-114
Benefits administered by Beacon Health Strategies. For more information, call (855) 750-8980 (toll free).		

For deductible and copay amounts, see the charts in the “Understanding Costs” section. All services must be medically necessary and all charges are subject to the allowed amount.

Description of Covered Services

The following pages contain descriptions of various covered services under the Medicare Extension Plan. Please see the "Benefit Highlights" section for benefit percentages and limits, copays, coinsurance amounts, deductibles, out-of-pocket limit exclusions and durations of benefits that apply to these covered services.

For copay and deductible amounts, see the "Understanding Costs" section.

The "Benefit Highlights" section also shows you the difference in the level of benefits for Medicare Extension Plan coverage with CIC (comprehensive insurance coverage) and without CIC. For information on the Plan's medical review requirements and to find out when prior authorization is needed, see the "Managed Care Program" section.

☎ Inpatient Hospital Services

Charges for the following services qualify as covered hospital charges if the services are for a hospital stay.

1. Room and board provided to the patient
2. Anesthesia, radiology and pathology services
3. Hospital pre-admission testing if you or your dependents covered under this Plan is scheduled to enter the same hospital where the tests are performed within seven days of the testing. If the hospital stay is cancelled or postponed after the tests are performed, the charges will still be covered as long as the physician presents a satisfactory medical explanation.
4. Medically necessary services and supplies charged by the hospital, except for special nursing or physician services
5. Physical, occupational and speech therapy
6. Diagnostic and therapeutic services

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

Services at Other Inpatient Facilities

Other inpatient facilities include:

- Sub-Acute Care Hospitals/Facilities
- Transitional Care Hospitals/Facilities
- Long-Term Care Hospitals/Facilities
- Chronic Disease Hospitals/Facilities
- Skilled Nursing Facilities

Covered charges for these facilities include the following services:

1. Room and board
2. Routine nursing care, but not including the services of a private duty nurse or other private duty attendant
3. Physical, occupational and speech therapy provided by the facility or by others under arrangements with the facility
4. Such drugs, biologicals, medical supplies, appliances, and equipment as are ordinarily provided by the facility for the care and treatment of its patients
5. Medical social services
6. Diagnostic and therapeutic services furnished to patients of the facility by a hospital or any other health care provider
7. Other medically necessary services as are generally provided by such treatment facilities

Coverage in Other Inpatient Facilities

To qualify for coverage in Other Inpatient Facilities, the purpose of the care in these facilities must be the reasonable improvement in the patient's condition. A physician must certify that the patient needs and receives, at a minimum, skilled nursing or skilled rehabilitation services on a daily or intermittent basis. Continuing care for a patient who has not demonstrated reasonable clinical improvement is not covered.

Emergency Treatment for an Accident or Sudden/Serious Illness

An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child.

Massachusetts provides a 911 emergency response system throughout the state. The Plan will cover medical and transportation expenses incurred as a result of the emergency medical conditions in accordance with the terms of the Plan. If you are faced with an emergency, call 911. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

Emergency services have the same level of coverage whether you have CIC or not.

Surgical Services

The payment to a surgical provider for operative services includes the usual pre-operative, intra-operative and post-operative care.

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or ambulatory surgery center)
2. Services of an assistant surgeon when:
   a) Medically necessary
   b) The assistant surgeon is trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
   c) The assistant surgeon serves as the first assistant surgeon (second or third assistants are not covered)
3. Reconstructive breast surgery:
   a) All stages of breast reconstruction following a mastectomy
   b) Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
   c) Coverage for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

   Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts. Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.
4. All other reconstructive and restorative surgery, but limited to the following:
   a) Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five years of the removal surgery.
   b) Correction of a congenital birth defect that causes functional impairment for a minor dependent child.

Medical Services

Charges for the following services qualify as covered medical charges, but only if they do not qualify as covered hospital or surgical charges:

1. **Ambulance/Air Ambulance** – Covered only in the event of an emergency and when medically necessary. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation to or from medical appointments, including dialysis, is not covered.
2. **Anesthesia** and its administration.
3. **Audiology Services** – Expenses for the diagnosis of speech, hearing and language disorders are covered when provided by a licensed audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered. The Plan does not cover services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states.
4. **Autism Spectrum Disorders** – Benefits are payable for charges incurred by a covered person for medically necessary diagnosis and treatment of autism spectrum disorders the same as those for any other physical condition. (See the "Mental Health, Substance Abuse and Enrollee Assistance Programs" section for coverage details.)
5. **Braces** – Replacement of such equipment is also covered when required due to pathological change or normal growth. Also see "Orthotics."
6. **Cardiac Rehabilitation Treatment** – Provided by a cardiac rehabilitation program (see the definition on page 59).
7. **Certified Nurse Midwife Services** – Provided in the home or in a hospital.
8. **Circumcision** – When provided for newborns up to 30 days from birth.
9. **Crutches** – Replacement of such equipment is also covered when required due to pathological change or normal growth.
10. **Diabetes** – Benefits will be paid for charges incurred by a covered person for medically necessary equipment, supplies and medications for the treatment of diabetes. Coverage will include outpatient self-management training and patient management, as well as nutritional therapy.

    Coverage will apply to services and supplies prescribed by a doctor for insulin dependent, insulin using, gestational and non-insulin using diabetes. The Plan will provide benefits for these services and supplies when prescribed by a physician under the medical component of the Plan or under the prescription drug plan as indicated below.

    Diabetic drugs, insulin and the following diabetic supplies are covered under the prescription drug component of the Plan:

    a) Blood glucose monitors
    b) Test strips for glucose monitors
    c) Insulin
    d) Syringes and all injection aids
    e) Lancets and lancet devices
    f) Prescribed oral agents
    g) Glucose agents and glucagon kits
    h) Urine test strips

The following diabetic supplies are covered under the medical component of the Plan:

a) Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons
b) Test strips for glucose monitors
c) Laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles
d) Insulin pumps and all related supplies
e) Insulin infusion devices
f) Syringes and all injection aids
g) Lancets and lancet devices
h) Urine test strips
i) Insulin measurement and administration aids for the visually impaired
j) Podiatric appliances for the prevention of complications associated with diabetes

Diabetes Self-Management Training
Diabetes self-management training and patient management, including medical nutritional therapy, may be conducted individually or in a group, but must be provided by:

- An education program recognized by the American Diabetes Association, or
- A health care professional who is a diabetes educator certified by the National Certification Board for Diabetes Educators

Coverage will include all educational materials for such program. Benefits will be provided as follows:

a) Upon the initial diagnosis of diabetes
b) When a significant change occurs in symptoms or conditions, requiring changes in self-management
c) When refresher patient management is necessary, or
d) When new medications or treatment are prescribed

As used in this provision, "patient management" means educational and training services furnished to a covered person with diabetes in an outpatient setting by a person or entity with experience in the treatment of diabetes. This will be in consultation with the physician who is managing the patient's condition. The physician must certify that the services are part of a comprehensive plan of care related to the patient's condition. In addition, the services must be needed to ensure therapy or compliance or to provide the patient with the necessary skills and knowledge involved in the successful management of the patient's condition.

11. **Early Intervention Services for Children** – Coverage of medically necessary early intervention services for children from birth until they turn three years old includes occupational therapy, physical therapy, speech therapy, nursing care, psychological counseling, and services provided by early intervention specialists or by licensed or certified health care providers working with an early intervention services program approved by the Department of Public Health. See page 35 for benefit limits.

12. **Family Planning Services** – Office visits and procedures for the purpose of contraception. Office visits include evaluations, consultations and follow-up care. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through the prescription drug plan.
13. **Fitness Club Reimbursement** – You can get reimbursed for up to $100 per family on your membership at a fitness club (see page 56). The reimbursement is paid once per year as a lump sum to the plan enrollee, upon proof of membership and payment. Use the form in Appendix C to submit a request for the fitness reimbursement.
14. **Gynecological Visits** – Annual gynecological examination, including Pap smear.
15. **Hearing Aids** – When prescribed by a physician. See the "Benefit Highlights" section for the benefit limit.
16. **Hearing Screenings** for newborns.
17. ☎ **Home Health Care** – Skilled services provided under a plan of care prescribed by a physician and delivered by a visiting nurse association (see definition on page 66) or a Medicare-certified home health care agency (see definition on page 61).

    The following services are only covered if the covered individual is receiving approved part-time, intermittent skilled care furnished or supervised by a registered nurse or licensed physical therapist:

    a) Part-time, intermittent home health aide services consisting of personal care of the patient and assistance with activities of daily living
    b) Physical, occupational, speech and respiratory therapy by the appropriate licensed or certified therapist
    c) Nutritional consultation by a registered dietitian
    d) Medical social services provided by a licensed medical social worker
    e) Durable medical equipment (DME) and supplies provided as a medically necessary component of a physician-approved home health services plan

    However, the following charges do not qualify as covered home health care charges:

    a) Charges for custodial care or homemaking services
    b) Services provided by you, a member of your family or any person who resides in your home. Your family consists of you, your spouse and your children, as well as brothers, sisters and parents of both you and your spouse.
18. **Infertility Treatment** – Non-experimental infertility procedures including, but not limited to:

    - Artificial Insemination (AI) also known as Intrauterine Insemination (IUI)
    - In Vitro Fertilization and Embryo Placement (IVF-EP)
    - Gamete Intrafallopian Transfer (GIFT)
    - Zygote Intrafallopian Transfer (ZIFT)
    - Natural Ovulation Intravaginal Fertilization (NORIF)

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

- Cryopreservation of eggs as a component of covered infertility treatment (costs associated with banking and/or storing inseminated eggs are reimbursable only upon the use of such eggs for covered fertility treatment)
- Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any
- Donor sperm or egg procurement and processing, to the extent such costs are not covered by the donor's insurer, if any
- Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility

In Vitro Fertilization and other associated infertility procedures, with the exception of artificial insemination, are limited to five attempts (see the definition of "Attempt" in "Plan Definitions").

The following are not considered covered services:

- Experimental infertility procedures
- Surrogacy
- Reversal of voluntary sterilization
- Procedures for infertility not meeting the Plan's definition (see page 62)

Facility fees will be considered as covered services by the Plan only from a licensed hospital or a licensed ambulatory surgery center.

19. **Laboratory Tests** – Must be ordered by a physician.
20. **Manipulative Therapy** – Chiropractic or osteopathic manipulation used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gain exists.
21. **Nurse Practitioner Services** – Medically necessary services provided in a hospital, clinic, professional office, home care setting, long-term care setting or any other setting when services are provided by a nurse practitioner who is practicing within the scope of his/her license.
22. **Occupational Therapy** – By a registered occupational therapist when ordered by a physician.
23. **Orthotics** – Covered when they meet the following criteria:
    - Ordered by a physician
    - Custom fabricated (molded and fitted) to the patient's body
24. **Oxygen** and its administration
25. **Physical Therapy** – Physical therapy used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gain exists. The Plan only covers one-on-one therapies rendered by a registered physical therapist or certified physical therapy assistant (under the direction of a physical therapist) and when ordered by a physician.
26. **Physician Assistant Services** – Medically necessary services provided in a hospital, clinic, professional office, home care setting, long-term care setting or any other setting when services are provided by a physician assistant who is practicing within the scope of his/her license.

27. **Physician Services** – Medically necessary services provided by a licensed physician acting within the scope of that license providing such services in the home, hospital, physician's office, or other medical facility. Physicians include any of the following providers acting within the scope of their licenses or certifications: physicians, certified nurse midwives, chiropractors, dentists, nurse practitioners, physician assistants, optometrists and podiatrists.

    Charges by physicians for their availability in case their services may be needed are not covered services. The Plan only pays physicians for the actual delivery of medically necessary services. Any charges for telephone and email consultations are not covered.

28. **Preventive Care** – The Plan covers preventive or routine level office visits or physical examinations and other related preventive services, including those recommended by the U.S. Preventive Services Task Force. See Appendix E for the complete preventive care schedule.

29. ☎ **Private Duty Nursing Services** – Highly skilled nursing services needed continuously during a block of time (greater than two hours) provided by a registered nurse while you are confined to your home. If you have CIC coverage, you can also use an LPN (licensed practical nurse) under some circumstances; see the "Benefit Highlights" section. Private duty nursing services must:
    a) Be medically necessary
    b) Provide skilled nursing services
    c) Be exclusive of all other home health care services, and
    d) Not duplicate services that a hospital or facility is licensed to provide

30. **Prostheses** – Replacement of such equipment is also covered when required due to pathological change or normal growth.

31. **Radiation Therapy** – Includes radioactive isotope therapy and intensity modulated radiation therapy (IMRT).

32. **Retail Medical Clinics** – Charges for medically necessary services for episodic, urgent care such as treatment for an earache or sinus infection at licensed retail medical clinics located at certain pharmacies. Flu vaccines may also be administered at these clinics.

33. **Routine Eye Examinations** (including refraction and glaucoma testing) – Covered once every 24 months.

34. **Routine Foot Care** – Charges for medically necessary routine foot care are covered if accompanied by medical evidence documenting:
    - In the case of an ambulatory patient, an underlying condition causing vascular compromise, such as diabetes, or
    - In the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.

35. **Speech-Language Pathology Services** – Expenses for the diagnosis and treatment of speech, hearing and language disorders are covered when provided by a licensed speech-language pathologist or audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered.

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

Covered speech-language pathology services include the following:

- The examination and remedial services for speech defects caused by physical disorders
- Physiotherapy in speech rehabilitation following laryngectomy

The Plan does not cover the following:

- Services that a school system must provide under Chapter 766 in Massachusetts or under a similar law in other states
- Language therapy for learning disabilities such as dyslexia
- Cognitive therapy or rehabilitation
- Voice therapy

36. **Tobacco cessation counseling** – Counseling for tobacco dependence/smoking cessation is covered up to a limit of 300 minutes per calendar year, reimbursed up to the Plan's allowed amount.

    - Counseling can occur in a face-to-face setting or over the telephone, either individually or in a group
    - Counseling may be provided by physicians, nurse practitioners, physician assistants, nurse-midwives, registered nurses and tobacco cessation counselors
    - Nicotine replacement products are available through the prescription drug plan
    - For information about additional counseling at no cost, call Customer Service

    To submit tobacco cessation counseling for coverage, use the form in Appendix C.

37. **Wigs** are covered only for the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The benefit is limited to $350 per calendar year.

38. **X-rays** and other radiological exams.

☎ Transplants

Benefits are payable, subject to deductibles, coinsurance, copays and limitations, for necessary medical and surgical expenses incurred for the transplanting of a human organ. (To receive the highest benefit, see "Quality Centers and Designated Hospitals for Transplants" on page 29.)

Human Organ Donor Services

Benefits are payable, subject to benefit limits, deductibles and limitations, for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of a human organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, whether or not the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, rules and regulations established by the Massachusetts Department of Public Health.

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

Hospice Care Services

Upon certification or re-certification by a physician that the covered individual is terminally ill, benefits are payable for charges incurred for the covered hospice care services when the member is enrolled in a Medicare-certified hospice program. The services must be furnished under a written plan of hospice care, established by a hospice and periodically reviewed by the medical director and interdisciplinary team of the hospice.

A person is considered to be terminally ill when given a medical prognosis of six months or less to live.

List of Covered Hospice Care Services

The Plan covers the following hospice care services:

1. Part-time, intermittent nursing care provided by or supervised by a registered nurse
2. Physical, respiratory, occupational and speech therapy by an appropriately licensed or certified therapist
3. Medical social services
4. Part-time, intermittent services of a home health aide under the direction of a registered nurse
5. Necessary medical supplies and medical appliances
6. Drugs and medications prescribed by a physician and charged by the hospice
7. Laboratory services
8. Physicians' services
9. Transportation needed to safely transport the terminally ill person to the place where that person is to receive a covered hospice care service
10. Psychological, social and spiritual counseling for the member furnished by a:
    a) Physician
    b) Psychologist
    c) Member of the clergy
    d) Registered nurse, or
    e) Social worker
11. Dietary counseling furnished by a registered dietitian
12. Respite care
13. Bereavement counseling furnished to surviving members of a terminally ill person's immediate family or other persons specifically named by a terminally ill person. Bereavement counseling must be furnished within twelve months after the date of death and it must be furnished by a:
    a) Physician
    b) Psychologist
    c) Member of the clergy
    d) Registered nurse, or
    e) Social worker

No hospice benefits are payable for services not included in this list, nor for any service furnished by a volunteer, or for which no charge is customarily made.

Hospital-Based Personal Emergency Response Systems (PERS)

Benefits are payable for the rental of a PERS if:

1. The service is provided by a hospital
2. The patient is homebound and at risk medically, and
3. The patient is alone at least four hours a day, five days a week, and is functionally impaired

No benefits are payable for the purchase of a PERS unit.

☎ Durable Medical Equipment (DME)

To meet the Plan's definition of DME, the service or supply must be:

1. Provided by a DME supplier
2. Designed primarily for therapeutic purposes or to improve physical function
3. Provided in connection with the treatment of disease, injury or pregnancy upon the recommendation and approval of a physician
4. Able to withstand repeated use, and
5. Ordered by a physician

Benefits are payable if the DME service or supply meets the Plan's definition of DME and is medically necessary, except as described in the "Excluded Services" section.

The Plan covers the rental of DME up to the purchase price. If the Plan determines that the purchase cost is less than the total expected rental charges, it may decide to purchase such equipment for your use. If you choose to continue to rent the equipment, the Plan will not cover rental charges that exceed the purchase price.

Excluded Items

No benefits are available for personal comfort items including, but not limited to, air conditioners, air purifiers, arch supports, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, whirlpools or spas. These items do not qualify as covered durable medical equipment.

Important: Using preferred vendors will maximize your benefits by reducing your member costs. See page 21 for more information. Note that if an item isn't available from a preferred vendor and you get it elsewhere, it will be covered at 80%.

☎ To get the highest benefit, you must notify UniCare when you have these services. The "Managed Care Program" section explains this requirement and lists the services that you must notify UniCare about.

Coverage for Clinical Trials for Cancer

Clinical trials are only covered for cancer treatment. The Plan covers patient care services provided as part of a qualified clinical trial only for the treatment of any form of cancer. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, utilization review and provider payment methods. In this context, patient care service means a health care item or service provided to an individual enrolled in a qualified clinical trial for cancer that is consistent with the patient's diagnosis, consistent with the study protocol for the clinical trial, and would otherwise be a covered benefit under the Plan. "Patient care service" does not include any of the following:

1. An investigational drug or device. However, a drug or device that has been approved for use in the qualified clinical trial will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device, regardless of whether the Food and Drug Administration has approved the drug or device for use in treating the patient's particular condition.
2. Non-health care services that a patient may be required to receive as a result of participation in the clinical trial.
3. Costs associated with managing the research of the clinical trial.
4. Costs that would not be covered for non-investigational treatments.
5. Any item, service or cost that is reimbursed or furnished by the sponsor of the clinical trial.
6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care.
7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration.
8. Services or costs that are not covered under the Plan.

Coverage for qualified clinical trials shall be subject to all the other terms and conditions of the policy, including, but not limited to, requiring the use of participating providers, provisions related to utilization review and the applicable agreement between the provider and the carrier.

The following services for cancer treatment are covered under this benefit:

1. All services that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.
2. The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial for cancer treatment to the extent it is not paid for by its manufacturer, distributor or provider.

Treatment of Cleft Lip and Cleft Palate for Children Under 18

The treatment of cleft lip and cleft palate in children under 18 is covered if the treating physician or surgeon certifies that the services are medically necessary and are specifically for the treatment of the cleft lip or palate.

Benefits for this treatment include:

- Medical
- Dental (if not covered by a dental plan)
- Oral and facial surgery
- Surgical management and follow-up care by oral and plastic surgeons
- Orthodontic treatment and management (if not covered by a dental plan)
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy (if not covered by a dental plan)
- Speech therapy
- Audiology
- Nutrition services

Benefits exclude any dental and orthodontic treatment covered by the member's dental plan.

You must notify Medical Case Management at least seven days before treatment is to begin.

Important: To access these benefits, contact Medical Case Management at (800) 442-9300.

Excluded Services

The Plan does not provide benefits for the following services. Please note that charges that are excluded by the Plan don't count toward your member costs or your out-of-pocket limit.

1. A service or supply furnished without the recommendation and approval of a physician (that is, without an order)
2. A service or supply reviewed under the Managed Care Program and determined by the Plan not to be medically necessary
3. A service or supply that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it, or that this treatment has been tried after others have failed, does not make it medically necessary.
4. A service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy, unless:
    a) Furnished by a hospital for routine care of a newborn child during a hospital stay that begins with birth and while the child's mother is confined in the same hospital,
    b) Furnished by a hospital or physician for covered preventive care, as outlined in Appendix E, or
    c) Such service or supply qualifies as a covered hospice care service (see page 47)
5. A service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law
6. A service or supply provided by you, a member of your family or by any person who resides in your home. Your family consists of you, your spouse and children, as well as brothers, sisters and parents of both you and your spouse.
7. A medical supply or service (such as a court-ordered test or an insurance physical) required by a third party that is not otherwise medically necessary. Examples of a third party are an employer, an insurance company, a school or a court.
8. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.
9. Acupuncture and acupuncture-related services
10. Anesthesia and other services required for the performance of a service that is not covered under the Plan. Non-covered services include those for which there is no Plan benefit and those that the Plan has determined to be not medically necessary.
11. Arch supports

Excluded Services

12. The amount by which a charge for blood is reduced by blood donations
13. Blood pressure cuff (sphygmomanometer)
14. Transportation in chair cars/vans
15. Any clinical research trial other than a qualified clinical trial for the treatment of cancer (see "Qualified Clinical Trials for Cancer" on page 64)
16. Cognitive rehabilitation or therapy
17. Computer-assisted communications devices
18. Custodial care
19. Dentures or dental prostheses
20. Services related to surgery undertaken as the result of denture wear or to prepare for the fitting of new dentures
21. Driving evaluations
22. Drugs not used in accordance with indications approved by the Food and Drug Administration (off-label use of a prescription drug), unless the use meets the definition of medically necessary as determined by the Plan or the drug is specifically designated as covered by the Plan
23. Over-the-counter drugs
24. Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies except for the following:
    a) A program established for its civilian employees
    b) Medicare (Title XVIII of the Social Security Act)
    c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
    d) A program of hospice care
25. Hearing aid batteries
26. Hippotherapy
27. Home construction or remodeling to accommodate a medical condition, such as the installation of a wheelchair ramp
28. Incontinence supplies
29. Experimental treatment for infertility
30. Internet providers or email consultations
31. Language therapy for learning disabilities such as dyslexia
32. Presbyopia-correcting intraocular lenses (IOLs) including, but not limited to, accommodating and multifocal IOLs designed to restore a fuller range of near, intermediate and far distances as compared to monofocal IOLs. Examples include Crystalens®, ReZoom® and AcrySof® ReSTOR.
33. Lift or riser chairs
34. Long-term maintenance care or long-term therapy

35. Certain manipulative or physical therapy services, including but not limited to: paraffin treatment; microwave, infrared and ultraviolet therapies; diathermy; massage therapy; acupuncture; aerobic exercise; rolfing therapy; Shiatsu; sports conditioning/weight training; craniosacral therapy; kinetic therapy; or therapies performed in a group setting
36. Massage therapy or services provided by a massage therapist or neuromuscular therapist
37. A medical service or supply for which a charge would not have been made in the absence of medical insurance
38. Any medical services, including in vitro fertilization, in connection with the use of a gestational carrier or surrogate
39. Benefits for the diagnosis, treatment or management of mental health/substance abuse conditions by medical (non-mental health) providers. These benefits are covered when provided by mental health providers (see pages 93-114 for coverage details).
40. Charges for missed appointments
41. Molding helmets and adjustable bands intended to mold the shape of the cranium
42. Orthodontic treatment, including treatment done in preparation for surgery
43. Orthopedic/corrective shoes, except when the shoe attaches directly to a brace
44. Orthopedic mattresses
45. Oxygen equipment required for use on an airplane or other means of travel
46. Personal comfort items that could be purchased without a prescription, such as air conditioners, air purifiers, bed pans, blood pressure monitors, commodes, dehumidifiers, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, telephones, televisions, whirlpools or spas and other similar items
47. Any physical therapy services provided by athletic trainers
48. Redundant or duplicate services. A service is considered redundant when the same service or supply is being provided or being used, concurrently, to treat the condition for which it is ordered.
49. Services received at non-medical religious facilities
50. Residential inpatient weight loss programs
51. Reversal of voluntary sterilization
52. Sensory integration therapy
53. Any services and treatments required under law to be provided by the school system for a child
54. Sexual reassignment surgery and related services
55. Stairway lifts and stair ramps
56. Storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with use in a scheduled procedure that is covered under the Plan

Excluded Services

57. Surface electromyography (SEMG)
58. Telephone consultations
59. Any type of hot or cold thermal therapy device
60. Virtual colonoscopy or virtual colonography (standard colonoscopy, however, is covered according to the preventive care schedule, outlined in Appendix E)
61. Vision care, including:
    a) Orthoptics or visual therapy for correction of vision
    b) Radial keratotomy and related laser surgeries
    c) Other surgeries, services or supplies furnished in conjunction with the determination or correction of refractive errors such as astigmatism, myopia, hyperopia and presbyopia (except as shown under "Routine Eye Examinations" on pages 36 and 45)
62. Voice therapy
63. Worksite evaluations performed by a physical therapist to evaluate a member's ability to return to work

Limited Services

The Plan limits benefits for the services and products described in this section.

1. **Ambulance** services are limited to transportation in the case of an emergency. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation required for medical appointments, including dialysis treatment, is not covered. Ambulance calls for transportation that is refused are also not covered. (See the definition of "Emergency" on page 60.)
2. **Air and sea ambulance** services are limited to the medically necessary transfer to the nearest facility equipped to treat the condition.
3. **Assistant surgeon services** are limited to the services of only one assistant surgeon per procedure when medically necessary. Second and third assistants are not covered.

   Non-physician assistants at surgery, such as nurse practitioners, nurses and technicians are not covered. Interns, residents and fellows are also not covered. Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.
4. **Cosmetic procedures/services** are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
5. **Dental benefits** are limited. The Medicare Extension Plan is a medical plan, not a dental plan. The Plan provides benefits for covered services relating to dental care or surgery in the following situations only:

   a) Emergency treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. This treatment is limited to the initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic X-rays.

   b) Oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are provided to the same extent as other covered surgical procedures described on page 66.

   c) The following procedures when a member has a serious medical condition[1] that makes it essential that he or she be admitted to a hospital as an inpatient, to a surgical day care unit or to an ambulatory surgery center as an outpatient, in order for the dental care to be performed safely:

      1. Extraction of seven or more teeth
      2. Gingivectomies (including osseous surgery) of two or more gum quadrants
      3. Excision of radicular cysts involving the roots of three or more teeth
      4. Removal of one or more impacted teeth

1 Serious medical conditions include, but are not limited to, hemophilia and heart disease.

d) The following services for the treatment of cleft lip or palate when prescribed by the treating physician or surgeon who certifies that the services are medically necessary and specifically for the treatment of cleft lip or palate:
   1. Dental
   2. Orthodontic treatment and management
   3. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy

Facility, anesthesia and related charges are only covered when the dental treatment or services are covered under the Plan.

Dentures or dental prostheses, and the surgery in preparation for dentures, are not covered under the Plan.

6. **Services or counseling from a dietician or nutritional counselor** are not covered, except for services performed by a registered dietician for:
   - Members with diabetes (see page 41 for details)
   - Adults at high risk for cardiovascular disease (services are limited to once every 12 months)
   - Children under 18 with cleft lip/palate
7. **Ear molds** are not covered, except when needed for hearing aids for members age 21 and under.
8. **Electrocardiograms (EKGs)** are not covered when done solely for the purpose of screening or prevention.
9. **Eyeglasses/contact lenses** are limited to the provision, replacement or fitting for the initial set only when subsequent to an injury to the eye or up to six months following cataract surgery.
10. **Fitness club reimbursement** is limited to a one-time payment per year. Any family member may have the fitness club membership, but payment is made to the Plan enrollee only. Fitness clubs are limited to health clubs or gyms that offer cardio and strength-training machines, and other programs for improved physical fitness. Martial arts centers, gymnastics centers, country clubs, beach clubs, sports teams and leagues, and tennis clubs are not considered fitness clubs. Personal trainers, sports coaches, yoga classes and exercise machines are also not eligible for the fitness reimbursement.
11. **Immunization titers**, which are performed to determine if a person has had a vaccination, are covered for pregnant women only.
12. **In Vitro Fertilization** and other associated infertility procedures, with the exception of artificial insemination, are limited to five attempts (see the definition of "Attempt" on page 58).
13. **Orthotics** are limited to medically necessary devices. Charges for test or temporary orthotics are not covered. Charges for video tape gait analysis and diagnostic scanning are not covered. Arch supports are also not covered.
14. **Respite care** is limited to a total of five days for a hospice patient in order to relieve the family or the primary care person from caregiving functions. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
15. **Retail medical clinics** are limited to providing care within the scope of their license in the state in which they are providing services.

16. **Routine screening** is not covered except according to the preventive care schedule outlined in Appendix E.
17. **Sperm, egg and/or inseminated egg** procurement and processing, and banking of sperm or inseminated eggs, are covered only for the treatment of infertility.
18. **Tobacco cessation counseling** is limited to 300 minutes per calendar year, based on the Plan's allowed amount. Counseling is also covered as a component of your preventive exam.
19. **Treatment of Temporomandibular Joint (TMJ) disorder** is limited to the initial diagnostic examination, initial testing and medically necessary surgery.
20. **Weight loss programs** are limited to the treatment of members whose body mass index (BMI) is 40 or more (morbidly obese) while under the care of a physician. Any such program is subject to periodic review. Residential inpatient weight loss programs are not covered.
21. **Wigs** are limited to the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The benefit is limited to $350 per calendar year.

Plan Definitions

Some terms used in this handbook are defined below as they relate to your benefits. Read these definitions carefully; they will help you understand what is covered under the Plan.

Acute Care – A level of care required as a result of the sudden onset or worsening of a condition that necessitates short term, intensive medical treatment. Acute inpatient care must be provided at a facility licensed as an acute care hospital. Also see "Hospital."

Allowed Amount – Either the amount Medicare allows for covered services or the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply – whichever is lower. This allowed amount may not be the same as the provider's actual charge. Allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

Ambulatory Surgery Center – See "Freestanding Ambulatory Surgery Center."

Ancillary Services – The services and supplies that a facility ordinarily renders to its patients for diagnosis or treatment during the time the patient is in the facility. Ancillary services include such things as:

- Use of special rooms, such as operating or treatment rooms
- Tests and exams
- Use of special equipment in the facility
- Drugs, medications, solutions, biological preparations and medical and surgical supplies used while an inpatient in the facility
- Administration of infusions and transfusions. This does not include the cost of whole blood, packed red cells, or blood donor fees.
- Devices that are an integral part of a surgical procedure. This includes items such as hip joints, skull plates and pacemakers. It does not include devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids.

Appeal – A request for the Plan to review a decision or a grievance.

Assistant Surgeon – A physician trained in the appropriate surgical specialty who serves as the first assistant to another surgeon during a surgical procedure. When medically appropriate, the service of only one assistant per procedure is covered under the Plan.

Attempt – The initiation of a reproductive cycle with the expectation of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:

- Commencement of drug therapy to induce ovulation, or
- Operative procedures for the purpose of implantation of a fertilized ovum

Autism Spectrum Disorders – Any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Balance Billing – When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. Under Massachusetts General Law, Chapter 32A: Section 20, Massachusetts providers are prohibited from balance billing you.

Calendar Year Deductible – The amount you owe for health care services the Plan covers before the Plan begins to pay. For example, if your deductible is $35, the Plan won't pay anything until you've met your $35 deductible for covered health care services subject to the deductible. The deductible doesn't apply to all services.

Cardiac Rehabilitation Program – A professionally-supervised, multi-disciplinary program to help people recover from heart attacks, heart surgery and percutaneous coronary intervention (PCI) procedures such as stenting and angioplasty. Treatment provides education and counseling services to help heart patients increase physical fitness, reduce cardiac symptoms, improve health and reduce the risk of future heart problems. The program must meet the generally accepted standards of cardiac rehabilitation.

CIC (Comprehensive Insurance Coverage) – Plan participants can elect CIC (comprehensive insurance coverage) or non-CIC (non-comprehensive insurance coverage). CIC increases the benefits for most covered services to 100%, subject to any applicable copays and deductibles. Members without CIC pay higher deductibles and receive only 80% coverage for some services.

Cognitive Rehabilitation or Cognitive Therapy – Treatment to restore function or minimize effects of cognitive deficits, including but not limited to those related to thinking, learning and memory.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance *plus* any copays and deductible you owe.

Copay (Copayment) – A fixed amount (for example, $20) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Not all services require copays.

Cosmetic Procedures/Services – Cosmetic services are those services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered, even if they are intended to improve a member's emotional outlook or treat a member's mental health condition.

Custodial Care – A level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

Deductible – See "Calendar Year Deductible."

Dependent

1. The employee's or retiree's spouse or a divorced spouse who is eligible for dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended
2. A GIC-eligible child, stepchild, adoptive child or eligible foster child
3. A GIC-eligible unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC

If you have questions about coverage for someone whose relationship to you is not listed above, contact the GIC.

Durable Medical Equipment (DME) – Equipment designed primarily for therapeutic purposes or to extend function that can stand repeated use and is medically necessary and prescribed by a physician. Such equipment includes wheelchairs, crutches, oxygen and respiratory equipment. Personal items related to activities of daily living such as commodes and shower chairs are not covered.

EAP (Enrollee Assistance Program) – Mental health services that include help for depression, marital issues, family problems, alcohol and drug abuse, and grief. EAP also includes referral services for legal, financial, family mediation, and elder care assistance. EAP services are administered by Beacon Health Strategies (see pages 93-114).

Early Intervention Services – Medically necessary services that include occupational, physical and speech therapy, nursing care and psychological counseling for children from birth until they turn three years old. These services must be provided by persons licensed or certified under Massachusetts law, who are working in early intervention programs approved by the Department of Public Health.

Elective – A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both. If you choose to have a procedure outside your home state, you may be balance billed.

Emergency – An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child. Emergency treatment does not include urgent care. Emergency treatment may be rendered in a hospital, in a physician's office or in another medical facility.

Enrollee – An employee, retiree or survivor covered by the GIC's health benefits program who is enrolled in the Plan.

Enteral Therapy – Prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Prescription and nonprescription enteral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Excluded Services – Health care services that the Plan doesn't pay for or cover.

Experimental or Investigational Procedure – A service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

Family Planning Services – Office visits and procedures for the purpose of contraception. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through your prescription drug plan.

Fitness Club – A health club or gym that offers cardio and strength-training machines and other programs for improved physical fitness.

Freestanding Ambulatory Surgery Centers – Independent, stand-alone facilities licensed to provide outpatient same-day surgical, diagnostic and medical services that require a dedicated operating room and a post-operative recovery room. These facilities are independent centers, not hospital-run facilities located in a hospital or elsewhere. The presence of a hospital name indicates that the site is a hospital facility, not an ambulatory surgery center.

High-Tech Imaging Services – Tests that vary from plain film X-rays by offering providers a more comprehensive view of the human body. Many of these tests also subject members to significantly higher levels of radiation compared to plain film X-rays and are also much more expensive. These procedures include but are not limited to MRIs, CT scans and PET scans.

Home Health Care – Health services and supplies provided by a home health care agency on a part-time, intermittent or visiting basis. Such services and supplies must be provided in a person's place of residence (not an institution) while the person is confined as a result of injury, disease or pregnancy. To be considered for coverage, home health care must be delivered by a visiting nurse association or a home health care agency certified by Medicare.

Home Health Care Plan – A plan of care for services in the home ordered in writing by a physician. A home health care plan is subject to review and approval by the Plan.

Home Infusion Company – A company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

Home Infusion Therapy – The administration of intravenous, subcutaneous or intramuscular therapies provided in the home setting. Subcutaneous and intramuscular drugs must be obtained through your prescription drug plan.

Hospice – A public agency or a private organization that provides care and services for terminally ill persons and their families and is certified as such by Medicare.

Hospital (Acute Care Hospital) – An institution that meets all of the following conditions:

1. Is operated pursuant to law for the provision of medical care
2. Provides continuous 24-hour-a-day nursing care
3. Has facilities for diagnosis
4. Has facilities for major surgery
5. Provides acute medical/surgical care or acute rehabilitation care
6. Is licensed as an acute hospital, and
7. Has an average length of stay of less than 25 days

The term "Hospital" does not include:

1. Rest homes
2. Nursing homes
3. Convalescent homes
4. Places for custodial care
5. Homes for the aged

Also see "Other Inpatient Facilities."

Hospital Outpatient Care – Care in a hospital that usually doesn't require an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Stay – The time a person is confined to a hospital and incurs a room and board charge for inpatient care other than custodial care.

Infertility – The condition of a healthy individual who is unable to conceive or produce conception:

1. During a period of one year if the female is age 35 or younger, except if the condition is caused by or the result of a voluntary sterilization or the normally occurring aging process.
2. During a period of six months if the female is over the age of 35, except if the condition is caused by or the result of voluntary sterilization or the normally occurring aging process.

If an individual conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one-year or six-month period, as applicable.

Injury – Bodily injury sustained accidentally by external means.

Manipulative Therapy – Hands-on treatment provided by a chiropractor, osteopath or physician by means of direct manipulation or movement to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system. See Exclusion 35 in the "Excluded Services" section for examples of manipulative therapies that are not covered.

Medically Necessary – With respect to care under the Plan, the treatment will meet at least the following standards:

1. Is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific member's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent ICD-9CM)
2. Is reasonably expected to improve or palliate the member's illness, condition or level of functioning
3. Is safe and effective according to nationally accepted standard clinical evidence generally recognized by medical professionals and peer-reviewed publications
4. Is the most appropriate and cost-effective level of care that can safely be provided for the specific member's diagnosed condition, and
5. Is based on scientific evidence for services and interventions that are not in widespread use

Note: The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device or drug does not, in and of itself, make it medically necessary or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.

Medical Supplies or Equipment – Disposable items prescribed by physicians as medically necessary to treat disease and injury. Such items include surgical dressings, splints and braces.

Member – An enrollee or his/her dependent who is covered by the Plan.

Non-Experimental Infertility Procedure – A procedure recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology.

Non-Preferred Vendor – A vendor who does not have a contract with either UniCare or Medicare to provide certain services or equipment, including but not limited to durable medical equipment and medical supplies. You have higher member costs when you use non-preferred vendors.

Nursing Home – An institution that:

1. Provides inpatient skilled care and related services, and
2. Is licensed in any jurisdiction requiring such licensing, but
3. Does not qualify as a skilled nursing facility (SNF) as defined by Medicare

A home, facility or part of a facility does not qualify as a skilled nursing facility or nursing home if it is used primarily for:

1. Rest
2. The care of drug abuse or alcoholism
3. The care of mental diseases or disorders
4. Custodial or educational care

Occupational Injury/Disease – An injury or disease that arises out of and in the course of employment for wage or profit (see the "Excluded Services" section).

Occupational Therapy – Skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include: treatment programs aimed at improving the ability to carry out activities of daily living; comprehensive evaluations of the home; and recommendations and training in the use of adaptive equipment to replace lost function.

Off-Label Use of a Prescription Drug – The use of a drug that does not meet the prescribed indications as approved by the Food and Drug Administration (FDA).

Orthotic – An orthopedic appliance or apparatus used to support, align or correct deformities and/or to improve the function of movable parts of the body. An orthotic must be ordered by a physician, be custom fabricated (molded and fitted) to the patient's body, and be for use by that patient only.

Other Inpatient Facilities – Includes the following hospitals/facilities:

1. Skilled nursing facilities
2. Chronic disease hospitals/facilities
3. Transitional care hospitals/facilities
4. Sub-acute care hospitals/facilities
5. Long-term care hospitals/facilities
6. Any inpatient facility with an average length of stay greater than 25 days

Out-of-Pocket Limit (with CIC only) – The most you could pay during a calendar year for coinsurance. After you reach this limit, the Plan begins to pay 100% of the allowed amount. This limit doesn't include your premium, balance-billed charges, copays, deductibles, or health care that the Plan doesn't cover. Not all coinsurance is included in the out-of-pocket limit (see the "Benefit Highlights" section for details).

There is no out-of-pocket limit for non-CIC plans.

Palliative Care – Care that focuses on treating symptoms – like severe pain, or difficulty breathing – to make patients more comfortable, and not intended to cure underlying conditions.

Physical Therapy – Hands-on treatment provided by a licensed physical therapist by means of direct manipulation, exercise, movement or other physical modalities to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system or following the loss of a body part. For examples of non-covered physical therapy services, see Exclusion 35 in the "Excluded Services" section.

Preferred Vendors – Providers who have contracted with either Medicare or UniCare, and whose services are covered at a higher benefit level. Preferred vendors are available for:

- Durable medical equipment (DME)
- Home health care
- Home infusion therapy
- Medical/diabetic supplies

For any of these services that Medicare covers, the preferred vendors are those providers that have a contract with Medicare (called "Medicare contract suppliers"). For services that Medicare doesn't cover but are covered by the Plan, the preferred vendors are providers that have a contract with UniCare.

Prostheses – Items that replace all or part of a bodily organ or limb and that are medically necessary and are prescribed by a physician. Examples include breast prostheses and artificial limbs.

Qualified Clinical Trials for Cancer – Clinical trials that, according to state law, meet all of the following conditions:

1. The clinical trial is to treat cancer.
2. The clinical trial has been peer reviewed and approved by one of the following:
    - United States National Institutes of Health
    - A cooperative group or center of the National Institutes of Health
    - A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants
    - The United States Food and Drug Administration pursuant to an investigational new drug exemption
    - The United States Departments of Defense or Veterans Affairs
    - With respect to Phase II, III and IV clinical trials only, a qualified institutional review board
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.
4. With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center.
5. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
6. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

7. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

Coverage for qualified clinical trials shall be subject to all the other terms and conditions of the policy, including, but not limited to, requiring the use of participating providers, provisions related to utilization review and the applicable agreement between the provider and the carrier.

Reconstructive and Restorative Surgery – Surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by one of the following:

- A congenital anomaly, or
- A previous surgical procedure or disease

Restoration of a bodily organ that is surgically removed during treatment of cancer must be performed within five years of surgical removal.

Rehabilitation Services – Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical therapy, occupational therapy, and speech-language pathology in a variety of inpatient and/or outpatient settings.

Respite Care – Services rendered to a hospice patient in order to relieve the family or primary care person from caregiving functions.

Retail Medical Clinics – Licensed medical clinics located at certain pharmacies that provide services by nurse practitioners or physician assistants for basic primary medical services. These services are limited to episodic, urgent care such as treatment for an earache or sinus infection. Retail medical clinics are limited to providing care within the scope of their license in the state in which they are providing services.

Skilled Care – Medical services that can only be provided by a registered or certified professional health care provider.

Skilled Nursing Facility (SNF) – An institution that:

1. Is operated pursuant to law
2. Is licensed or accredited as a skilled nursing facility if the laws of the jurisdiction in which it is located provide for the licensing or the accreditation of a skilled nursing facility
3. Is approved as a skilled nursing facility for payment of Medicare benefits or is qualified to receive such approval, if requested
4. Is primarily engaged in providing room and board and skilled care under the supervision of a physician
5. Provides continuous 24-hour-a-day skilled care by or under the supervision of a registered nurse (RN), and
6. Maintains a daily medical record of each patient

A home, facility or part of a facility does not qualify as a skilled nursing facility or nursing home if it is used primarily for:

1. Rest
2. The care of mental diseases or disorders
3. The care of drug abuse or alcoholism, or
4. Custodial or educational care

Sleep Studies – Tests that monitor you while you sleep to find out if there are any breathing difficulties. These studies may be performed at a hospital, a freestanding sleep center or at home. Sleep studies are covered under the benefit for diagnostic laboratory testing.

Spouse – The legal spouse of the covered employee or retiree.

Surgical Procedure – Any of the following types of treatment:

1. A cutting procedure
2. The suturing of a wound
3. The treatment of a fracture
4. The reduction of a dislocation
5. Radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor
6. Electrocauterization
7. Diagnostic and therapeutic endoscopic procedures
8. Injection treatment of hemorrhoids and varicose veins
9. An operation by means of laser beam
10. Any other procedures classified as surgery by the American Medical Association (AMA), such as skin tag or wart removal.

Temporomandibular Joint (TMJ) Disorder – A syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

Terminal Illness – An illness that, because of its nature, can be expected to cause the patient to die.

Tobacco Cessation Counselors – Non-physician providers who have completed at least 8 hours of instruction in tobacco cessation from an accredited institute of higher learning. Tobacco cessation counselors must work under the supervision of a physician.

Tobacco Cessation Program – A program that focuses on behavior modification while reducing the amount smoked over a number of weeks, until the quit, or cut-off, date.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Visiting Nurse Association – An agency certified by Medicare that provides part-time, intermittent skilled care and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing.

Written Proof – Satisfactory proof, in writing, of the incurral of a claim.

General Provisions

This section describes the enrollment process for you and your eligible dependents; when coverage begins and ends; and continuing coverage when eligibility status changes.

Free or Low-Cost Health Coverage for Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. For more information, see Appendix D, "Federal and State Mandates," at the back of this handbook.

Application for Coverage

You or your dependents must be enrolled in Medicare Parts A and B to be eligible to join the Medicare Extension Plan.

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, contact the GIC.

To enroll newborns

You must enroll a child within 31 days of the child's birth. You must submit a written request for coverage to the GIC and include a copy of the child's birth certificate.

To enroll or add your dependents

You must enroll each additional dependent when he or she becomes eligible. If you marry, you must enroll your spouse within 31 days of the marriage.

To enroll adopted children

Adopted children must be enrolled within 31 days of placement in the home. Send a written request to the GIC along with a letter from the adoption agency that states the date the child was placed in the home.

When Coverage Begins

Coverage under the Plan starts as follows:

For persons applying during an annual enrollment period

Coverage begins on the following July 1.

For dependents

Coverage begins on the later of:

1. The date your own coverage begins, or
2. The date on which the GIC has determined your dependent is eligible and qualifies as a dependent

For new retirees, spouses and surviving spouses

You will be notified by the GIC of the date on which coverage begins.

Continued Coverage

Your eligibility for these benefits continues if you are:

1. An employee of the Commonwealth, a municipality or other entity that participates in the GIC who is enrolled in Medicare Parts A and B
2. A retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is enrolled in Medicare Parts A and B
3. The spouse of a retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is enrolled in Medicare Parts A and B, or
4. The surviving spouse of an employee or retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is enrolled in Medicare Parts A and B

When Coverage Ends for Enrollees

Your coverage ends on the earliest of:

1. The end of the month covered by the last contribution toward the cost of your coverage
2. The end of the month in which you cease to be eligible for coverage
3. The date the enrollment period ends
4. The date of death
5. The date the survivor remarries, or
6. The date the Plan terminates

When Coverage Ends for Dependents

A dependent's coverage ends on the earliest of:

1. The date your coverage under the Plan ends
2. The end of the month covered by your last contribution toward the cost of such coverage
3. The date you become ineligible to have dependents covered
4. The date the enrollment period ends
5. The date the dependent ceases to qualify as a dependent
6. The date the dependent child, who is permanently and totally disabled and became so by age 19, marries
7. The date the divorced spouse remarries (or the date the enrollee marries, depending on the divorce decree)
8. The date of the dependent's death, or
9. The date the Plan terminates

Duplicate Coverage

No person can be covered by any other GIC health plan at the same time as:

1. Both an employee, retiree or surviving spouse and a dependent, or
2. A dependent of more than one covered person (employee, retiree, spouse or surviving spouse)

Special Enrollment Condition

If you have declined the Plan for your spouse or for your dependents because they have other health coverage, you may be able to enroll them during the Plan year if the other coverage is lost. To obtain the appropriate enrollment forms, contact the GIC in writing.

Continuing Coverage

The following provisions in this section explain how coverage may be continued or converted if eligibility status changes.

Continuing Health Coverage Due to Involuntary Layoff

If you are no longer eligible for coverage due to involuntary layoff, you may have coverage under the Plan continued for 39 consecutive weeks. This coverage would apply to you and all of your dependents who are covered under the Plan at the time you are laid off.

In the event of involuntary layoff, the person who has the option to continue coverage must:

1. Elect to continue, in writing, within 30 days after the date eligibility for coverage ends, and
2. Pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. The end of the month of 39 consecutive weeks following the date you cease to be eligible for coverage
2. The end of the month covered by the last contribution toward the cost of your coverage
3. The date the coverage ends
4. The date the Plan terminates, or
5. In the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage

Option to Continue Coverage as a Deferred Retiree

You are eligible for deferred retirement if you:

1. Have 10 or more years of full-time service (as determined by the State Retirement Board or a public retirement system), and
2. Are eligible for a pension from the State Retirement Board or a public retirement system that participates with the GIC, and
3. Are leaving your retirement monies in a public retirement system

The person who chooses to continue health coverage as a deferred retiree must:

1. Contact the GIC for enrollment information, and
2. Pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. The end of the month covered by the last contribution toward the cost of your coverage
2. The date the coverage ends
3. The date the Plan terminates
4. In the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage, or
5. The date you withdraw your monies from the retirement system

Continuing Health Coverage for Survivors

Surviving spouses of covered employees or retirees and/or their eligible dependent children may be able to continue coverage under this health care program. Surviving spouse coverage ends upon remarriage. Orphan coverage is also available for some surviving dependents. For more information on eligibility for survivors or orphans, contact the GIC.

To continue coverage, the person who has the option to continue coverage must:

1. Elect to continue, in writing, within 30 days after the date of your death, and
2. Make the required contribution toward the cost of the coverage

Coverage for survivors will end on the earliest of these dates:

1. The end of the month in which the survivor dies
2. The end of the month covered by the last contribution payment for the coverage
3. The date the coverage ends
4. The date the Plan terminates
5. In the case of a dependent, the date that dependent would cease to qualify as a dependent, or
6. The date the survivor remarries

Option to Continue Coverage for Dependents Age 26 and Over

A dependent child who reaches age 26 is no longer automatically eligible for coverage under this Plan. A full-time student at an accredited educational institution at age 26 or over may continue to be covered as a dependent family member, but must pay 100% of the required monthly individual premium. That student must file a written application with the GIC within 30 days of his or her 26^{th} birthday, and the application must be approved by the GIC. Full-time students age 26 and over are not eligible for continued coverage if there has been a two year break in the dependent's GIC coverage. If the application is submitted late, your dependent may have a gap in coverage.

Option to Continue Coverage after a Change in Marital Status

Your spouse will not cease to qualify as a dependent solely because a judgment of divorce or of separate support is granted. If that judgment is granted while the former spouse is covered as a dependent and states that coverage for the former spouse will continue, that person will continue to qualify as a dependent under the Plan, provided family coverage continues, neither party remarries and is eligible for coverage in accordance with Massachusetts General Laws Chapter 32A as amended.

If you get divorced, you must notify the GIC and send them a copy of your divorce decree. If you or your former spouse remarry, you must also notify the GIC.

The former spouse will no longer qualify as a dependent after the earliest of these dates:

1. The end of the period specified in the judgment during which that person must remain eligible for coverage
2. The end of the month covered by the last contribution toward the cost of the coverage
3. The date that person remarries
4. The date you remarry. If that person is still covered as a dependent on this date, and the judgment gives that person the right to continue coverage at full cost after you remarry, then that person may either elect to:
   a) Remain covered separately for the benefits for which he or she was covered on that date
   b) Enroll in COBRA coverage, or
   c) Have a converted policy issued to provide those benefits

For the purposes of this provision, "judgment" means only a judgment of absolute divorce or of separate support.

Group Health Continuation Coverage under COBRA Election Note

You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

What is COBRA Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at (617) 727-2310, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

Who is Eligible for COBRA Coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

How Long Does COBRA Coverage Last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and When Do I Elect COBRA Coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How Much Does COBRA Coverage Cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and When Do I Pay for COBRA Coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but

you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I Elect Other Health Coverage Besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority. The GIC has no involvement in conversion programs, and only very limited involvement in or Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The insured dies;
  - The insured becomes legally separated or divorced;
  - The insured or insured's former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. ***To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-0998.***

Conversion to Non-Group Health Coverage

Under certain circumstances, a person whose Plan coverage is ending has the option to convert to non-group health coverage arranged for by UniCare.

A certificate for this non-group health coverage can be obtained if:

1. Employment for coverage purposes ends, except due to retirement, or
2. Status changes occur for someone who is not eligible for continued coverage under the Plan

You cannot obtain a certificate of coverage if you are otherwise eligible under the Plan, or if your coverage terminated for failure to make a required contribution when due. In addition, no certificate of coverage will be issued in a state or country where UniCare is not licensed to issue it.

The certificate of coverage will cover you and your dependents who cease to be covered under the Plan because your health coverage ends, and any child of yours born within 31 days after such coverage ends.

A certificate of coverage is also available to the following persons whose coverage under the Plan ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under the Plan solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents, if their coverage ceases because of a change in marital status

The following rules apply to the issuance of the certificate of coverage:

1. Written application and the first premium must be submitted within 31 days after the coverage under the Plan ends.
2. The rules of UniCare for coverage available for conversion purposes at the time application for a certificate of coverage is received govern the certificate. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable and all other terms and conditions of such certificate.
3. If delivery of the certificate is to be made outside Massachusetts, it may be on such form as is offered in the state where such certificate is to be delivered.
4. The certificate of coverage will become effective on the day after coverage under the Plan ends.
5. No evidence of insurability will be required.

UniCare will furnish details of converted coverage upon request.

Coordination of Benefits (COB)

You and your dependents may be entitled to receive benefits from more than one plan. For instance, you may be covered as a dependent under your spouse's plan in addition to coverage under your own plan, or your child may be covered under both plans. When you or your dependents are covered by two or more plans, one plan is identified as the primary plan for coordination of benefits (COB) and determining the order of payment. Any other plan is then the secondary plan.

Some providers choose not to participate in the Medicare Program. If members use these providers for services that Medicare normally covers, the UniCare State Indemnity Plan will only consider for payment the amount that would have been allowed if Medicare had processed the claim as the primary carrier.

> **Example** – If you choose to visit a provider who does not participate in Medicare and the charge is $100, it is assumed that Medicare would have paid $80, leaving $20 in coinsurance. The Plan will apply its benefit to the $20 and the provider may bill you for the difference.

If the UniCare State Indemnity Plan is the primary plan, benefit payments will be made in accordance with the benefits payable under the Plan without taking the other plan's benefits into consideration. A secondary plan may reduce its benefits if payments were paid by the UniCare State Indemnity Plan. If another plan is primary, benefit payments under the UniCare State Indemnity Plan are determined in the following manner:

a) The Plan determines its covered expenses – in other words, what the Plan would pay in the absence of other insurance, then
b) The Plan subtracts the primary plan's benefits from the covered expenses determined in (a) above, and then
c) The Plan pays the difference, if any, between (a) and (b)

The term **primary plan's benefit** includes the benefit that would have been paid had the claim been filed with the other plan. For those plans that provide benefits in the form of services, the reasonable cash value of each service is considered as the charge and as the benefit payment. All COB is determined on a calendar year basis for that part of the year the person had coverage under the Plan.

For the purposes of COB, the term **plan** is defined as any plan, including HMOs, that provides medical or dental care coverage including, but not limited to, the following:

- Group or blanket coverage
- Group practice or other group prepayment coverage, including hospital or medical services coverage
- Labor-management trusteed plans
- Union welfare plans
- Employer organization plans
- Employee benefit organization plans
- Coverage under a governmental plan, or coverage required or provided by law. This would include any legally required, no-fault motor vehicle liability insurance. This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.
- Automobile no-fault coverage

The term **plan** does not include school-accident type plans, or coverage that you purchased on a non-group basis.

Determining the Order of Coverage

The following are the rules by which the UniCare State Indemnity Plan and most other plans determine order of payment – that is, which plan is the primary plan and which plan is the secondary plan:

1. The plan without a COB provision is primary.
2. The plan that covers the person as an employee, member, or retiree (that is, other than a dependent) determines benefits before the plan that covers the person as a dependent.
3. The order of coverage for a dependent child who is covered under both parents' plans is determined as follows:
   a) The primary plan is the plan of the parent whose annual birthday falls first in the calendar year, or
   b) If both parents have the same birthday, the primary plan is the plan that has covered a parent for the longest period of time

   This is called the **birthday rule**. However, if the other plan has a rule based on the gender of the parent, and, if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.
4. The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, is determined in the following order:
   a) First, the plan of the parent who is decreed by the court as financially responsible for the health care expenses of the child
   b) Second, if there is no court decree, the plan of the parent with custody of the child
   c) Third, if the parent with custody of the child is remarried, the plan of the stepparent
   d) Finally, the plan of the parent who does not have custody of the child
5. The plan that covers a person as an active employee (that is, someone who is not laid off or retired) determines benefits for that person and his or her dependents before the plan that covers that same person as a retiree.

   This is called the **active before retiree rule**. However, if the other plan's rule is based on length of coverage, and, if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied when trying to determine the order of coverage, the plan that has covered the person longer determines benefits before the plan that has covered that same person for the shorter period of time.

Right to Receive and Release Information

In order to fulfill the terms of this COB provision or any other provision of similar purpose:

- A claimant must provide the Plan with all necessary information
- The Plan may obtain from or release information to any other person or entity

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the UniCare State Indemnity Plan. If it does, the UniCare State Indemnity Plan may pay that amount to the organization that made the payment. That amount will be treated as if it were a benefit payable under the UniCare State Indemnity Plan. The UniCare State Indemnity Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of payments made by the Plan is more than it should have been under the COB provision, the Plan may recover the excess from one or more of the following:

- The persons it has paid or for whom it has paid
- Insurance companies, or
- Other organizations

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

PART 2

PRESCRIPTION DRUG PLAN

Description of Benefits

Administered by

CVS CAREMARK

Prescription Drug Plan

CVS Caremark[1] is the pharmacy benefit manager for your prescription drug benefit plan. The CVS Caremark pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail service pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact CVS Caremark Customer Care toll free at (877) 876-7214, TDD: (800) 238-0756.

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter versions of omeprazole (omeprazole OTC), Prevacid (Prevacid OTC), Prilosec (Prilosec OTC) and Zegerid (Zegerid OTC), medications are covered only if a prescription is required for their dispensing. Diabetic supplies and insulin are also covered by the plan.

The plan categorizes medications into six major categories:

Generic Drugs

Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements help to assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug

A maintenance drug is a medication taken on a regular basis for chronic conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Brand-Name Drug

A non-preferred brand-name drug, or non-formulary drug, is a medication that usually has an alternative therapeutically equivalent drug available on the formulary.

Preferred Brand-Name Drug

A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.

Specialty Drugs

Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Potential for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

1 CVS Caremark provides services through its operating company Caremark PhC, L.L.C. and affiliates.

Over-the-Counter (OTC) Drugs

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of omeprazole OTC, Prevacid OTC, Prilosec OTC and Zegerid OTC (which are covered only if dispensed with a written prescription).

Copayments

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (most generic drugs), Tier 2 (mostly preferred brand-name drugs), Tier 3 (non-preferred brand-name drugs), or drugs which require no copayments. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

Table 5. Copayments for Prescription Drugs

Copayment for	Participating Retail Pharmacy up to 30-day supply	Mail Service or CVS/pharmacy up to 90-day supply
Tier 1 **Generic Drugs and** • Omeprazole OTC, Prevacid OTC, Prilosec OTC and Zegerid OTC *(28-day supply – retail; 84-day supply – mail)*[1]	$10	$20
Tier 2 **Preferred Brand-Name Drugs and** • Generic versions of Aciphex (rabeprazole), Prevacid (lansoprazole) and Zegerid (omeprazole/sodium bicarbonate)	$25	$50
Tier 3 **Non-Preferred Brand-Name Drugs**	$50	$110
Other • Orally-administered anti-cancer drugs • Women's contraceptive drugs, devices and products	$0	$0
Copayment for	**Specialty Drugs – Two 30-day prescriptions allowed at any participating pharmacy; thereafter must be filled only through CVS Caremark Specialty Pharmacy**	
Specialty Drugs: Tier 1	$10 up to a 30-day supply	
Specialty Drugs: Tier 2	$25 up to a 30-day supply	
Specialty Drugs: Tier 3	$50 up to a 30-day supply	
Orally-administered anti-cancer specialty drugs	$0 up to a 30-day supply	

1 Due to manufacturer packaging

How to Use the Plan

After you first enroll in the plan, CVS Caremark will send you a benefit booklet and CVS Caremark Prescription Card(s) for you and your dependents. Your Prescription Card(s) will be mailed to you and your dependents (if any) in separate mailings from the benefit booklet. (Please note: You may receive Prescription Cards *before* you receive the benefit booklet).

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register on www.caremark.com. As a registered user, you can check drug costs, order mail service refills, and review your prescription drug history. You can access this site 24 hours a day.

Filling Your Prescriptions

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through the CVS Mail Service Pharmacy. Prescriptions for specialty drugs must be filled as described in the "CVS Caremark Specialty Pharmacy" subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your CVS Caremark Prescription Card, with the exception of the limited circumstances detailed in the "Claim Forms" subsection.

Short-Term Medications – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (example: antibiotics for strep throat or painkillers for an injury). Simply present your CVS Caremark Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at www.caremark.com or by calling toll free at (877) 876-7214.

If you do not have your Prescription Card, you can provide your pharmacist with the cardholder's Social Security or GIC ID number, Bin number (610029), group code (GICRX) and the RxPCN code (CRK). The pharmacist can also verify eligibility by contacting the CVS Caremark Pharmacy Help Desk toll free at (800) 421-2342, TDD: (800) 238-0756.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will be contacted by CVS Caremark to explain how you may convert your prescription to a 90-day supply to be filled either through mail service or at a CVS/pharmacy. You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail service or at a CVS/pharmacy, or if you inform CVS Caremark that you instead prefer to continue to receive 30-day supplies at a participating retail pharmacy.

CVS Caremark will assist you in transitioning your maintenance prescription to either mail service or a CVS/pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions through CVS Caremark Mail Service Pharmacy or CVS/pharmacy

You have the choice and convenience of filling maintenance prescriptions for up to 90-day supply at the mail service copayment, either through the CVS Caremark Mail Service Pharmacy or at a CVS/pharmacy.

Mail service is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure and high cholesterol. Your prescriptions are filled and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection. They are delivered directly to your home or to another location that you prefer.

CVS/pharmacy is another option for getting your 90-day maintenance medications for the same copayment amount as mail service. Prescriptions can be filled at one of over 7,000 CVS/pharmacy locations across the country.

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail service, or the option of your local CVS/pharmacy, you can order refills online or by phone.

Using Mail Service

To begin using mail service for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a mail order form (contained in your Welcome Kit or found online after registering at www.caremark.com). Or call CVS Customer Care toll free at (877) 876-7214 to request the form.
3. Put your prescription, payment and completed order form into the return envelope (provided with the order form) and mail it to CVS Caremark.

Please allow 7-10 business days for delivery from the time your order is mailed. A pharmacist is available 24 hours a day to answer your questions about your medication.

If the CVS Caremark Mail Service Pharmacy is unable to fill a prescription because of a shortage of the medication, CVS Caremark will notify you of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a full-service specialty pharmacy that provides personalized care to each patient. You are allowed two fills of a specialty drug at any participating retail pharmacy. After these two fills, a specialty drug must be filled only at the CVS Caremark Specialty Pharmacy.

Specialty medications may be filled only at a maximum of a 30-day supply. They are subject to a clinical review by CVS Caremark's Specialty Guideline Management program to ensure the medications are being prescribed appropriately.

CVS Caremark Specialty Pharmacy offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. CVS Caremark Specialty Pharmacy will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CVS Caremark Specialty Pharmacy, call Caremark Connect toll free at (800) 237-2767.

CVS Caremark Specialty Pharmacy Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, a CVS/pharmacy or other approved location
- **Refill Reminders** – Ongoing refill reminders from CVS Caremark Specialty Pharmacy
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

CVS Caremark Specialty Pharmacy serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple sclerosis and rheumatoid arthritis.

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your CVS Caremark Prescription Card, are covered as follows:

Table 6. Claims Reimbursement

Type of Claim	Reimbursement
Claims for prescriptions for plan members who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.[1]	Claims will be reimbursed at the full cost submitted, less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without a CVS Caremark Prescription ID Card.	Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.
Claim forms are available to registered users on www.caremark.com or by calling (877) 876-7214.	

Other Plan Provisions

Brand-Name Drugs with Exact Generic Equivalents

The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor, Ambien and Fosamax, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. Exceptions to this provision may apply to certain brand-name contraceptives; contact CVS Caremark for additional information.

Prescription Drugs with OTC Equivalents or Alternatives

Some prescription drugs have OTC equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. For example, OTC alternatives to Clarinex, a prescription drug, are the OTC products Allegra, Claritin and Zyrtec. Your plan does not provide benefits for prescription drugs when OTC alternatives are available.

1 Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.

Prior Authorization

Some drugs in your plan require prior authorization. If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call CVS Caremark Prior Authorization at (800) 626-3046.

Table 7. Current examples of drugs requiring Prior Authorization[1]

Abstral	Fabrazyme	Nuvigil	Somavert
Actemra	Fentora	Olysio	Sovaldi
Acthar HP	Forteo	Omontys	Sporanox
Actimmune	Gel-One	Onglyza	Stelara
Actiq	Gilenya	Onmel	Subsys
Adagen	Granix	Onsolis	Supartz
Adcirca	Growth Hormone Agents	Opsumit	Synagis
Adempas	Hemophilia Agents	Orencia	Synvisc
Amevive	Hizentra	Orthovisc	Tazorac
Ampyra	Humira	Oseni	Tecfidera
Anabolic Steroids such as Anadrol and Oxandrin	Hyalgan	Otrexup	Testosterone Products such as Androderm, Androgel and Testim
Aralast	Immune Globulin Products	Pegasys	Thyrogen
Aranesp	Incivek	Peg-Intron	Tobi
Aubagio	Kalydeco	Penlac	Tracleer
Avonex	Kazano	Pradaxa	Tysabri
Benlysta	Kineret	Privigen	Tyvaso
Betaseron	Kombiglyze XR	Procrit	Ventavis
Bethkis	Kynamro	Prolastin-C	Victrelis
Botox	Lamisil	Prolia	Vivitrol
Cayston	Lazanda	Promacta	Weight Loss Drugs
Cerezyme	Letairis	Provigil	Xeljanz
Cimzia	Lucentis	Pulmozyme	Xenazine
Copaxone	Lupron Depot	Rebif	Xeomin
Dysport	Makena	Reclast	Xiaflex
Enbrel	Myobloc	Regranex	Xolair
Epogen	Nesina	Remicade	Xyrem
Euflexxa	Neulasta	Revatio	Zemaira
Exjade	Neupogen	Ribavirin	
Extavia	Nplate	Sandostatin	
Fabior	Nutritional Supplements	Sensipar	
		Simponi	
		Somatuline	

For members over the age of 35: Retin-A, Retin-A Micro, Avita, Tretin-X, Atralin gel, topical tretinoin, Veltin, Ziana

1 This list is subject to change during the year. Call CVS Caremark toll free at (877) 876-7214 to check if your drugs are included in the program.

Quantity Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- FDA-approved product labeling
- Common usage for episodic or intermittent treatment
- Nationally accepted clinical practice guidelines
- Peer-reviewed medical literature
- As otherwise determined by the plan

Examples of drugs with quantity limits currently include Flonase, Imitrex, Levitra, and Viagra.[1]

Step Therapy

In some cases, your plan requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases. Your prior claims history, if you are a continuing member of the plan, will show whether first-line prescription drugs have been purchased within a specified time frame (in most cases, within the previous 180 days), allowing the second-line medication to be approved without delay.

If you have not had a medication filled within the specified time frame while a member of this plan, a first-line prescription drug must be used and the Step Therapy requirements will apply to your prescription.

In certain situations, a member may be granted an authorization for a second-line prescription drug without the prior use of a first-line prescription drug if specific medical criteria have been met.

Unless you meet certain medical criteria or have a prior history of use of the first-line prescription drug, your pharmacist will receive a message that the prescription will not be covered. The message will list alternative, first-line drugs that could be used. You or your pharmacist will then need to contact your physician to have your prescription changed, or you will have to pay the full cost of the prescription. If you are using mail service, CVS Caremark will notify you of a delay in filling your prescription and will contact your physician about switching to a first-line prescription drug. If your physician does not respond within two business days, CVS Caremark will not fill your prescription and will return it to you.

The chart on page 88 shows current examples of prescription drugs that require Step Therapy.

1 This list is subject to change during the year. Call CVS Caremark toll free at (877) 876-7214 to check if your drugs are included in this program.

Table 8. Current examples of prescription drugs requiring Step Therapy[1]

Condition	Drug
Allergies & Asthma	Beconase AQ, Dymista, Nasonex, Omnaris, Qnasl, Rhinocort Aqua, Veramyst, Zetonna
Antidepressants	Brintellix, Fetzima, Khedezla, Pexeva, Pristiq, Viibryd
Anti-infectives	Solodyn
Autoimmune (inflammatory bowel disease, psoriasis, rheumatoid arthritis)	Actemra, Cimzia, Kineret, Orencia/SQ, Remicade, Simponi, Simponi Aria, Stelara, Xeljanz
Benign Prostatic Hypertrophy (BPH)	Avodart, Jalyn
Gout	Uloric
Growth Hormones	Genotropin, Nutropin, Omnitrope, Saizen, Tev-Tropin
High Blood Pressure	Amturnide, Diovan, Edarbi, Edarbyclor, Exforge/HCT, Tekalmo, Tekturna/HCT, Tribenzor
High Cholesterol	Advicor, Altoprev, LescolXL, Liptruzet, Livalo, Simcor, Vytorin, Zetia
Incontinence	Enablex, Gelnique, Myrbetriq, Oxytrol, Toviaz, VESIcare
Insomnia	Edluar, Intermezzo, Lunesta, Rozerem, Silenor, Zolpimist
Multiple Sclerosis	Aubagio, Betaseron, Rebif, Tysabri
Neuropathy	Lyrica
Osteoporosis	Actonel, Actonel Plus Calcium, Atelvia, Binosto, Fosamax Plus D, Fosamax Solution, Skelid
Pain/Arthritis	Cambia, Celebrex, Duexis, Flector, Nalfon, Naprelan CR, Pennsaid, Vimovo, Voltaren gel, Zipsor, Zorvolex
Topical Dermatitis	Elidel, Protopic
Topical Steroids	Brand topical steroid products such as Apexicon-E, Clobex, Locoid, Vanos

Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the plan;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

1 This list is subject to change during the year. Call CVS Caremark toll free at (877) 876-7214 to check if your drugs are included in the program.

Exclusions

Benefits exclude:[1]

- Nexium and Aciphex
- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and OTC versions of omeprazole, Prevacid, Prilosec or Zegerid)
- Non-sedating antihistamines
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Allergens
- Hair growth agents
- Special medical formulas or food products, except as required by state law

Definitions

Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Diabetic Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail service settings. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

1 This list is subject to change during the year.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Brand-Name Drug – A non-preferred brand-name drug, or non-formulary drug, is a medication that has been reviewed by CVS Caremark, which determined that an alternative drug that is clinically equivalent and more cost effective may be available.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of omeprazole OTC, Prevacid OTC, Prilosec OTC and Zegerid OTC (which are covered if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the CVS Caremark nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

Preferred Brand-Name Drug – A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription" or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Prior Authorization – Prior authorization means determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products may require prior authorization to determine medical necessity.

For inherited diseases of amino acids and organic acids, food products modified to be low protein are covered up to $5,000 per calendar year per member.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at (617) 727-2310, extension 1.

Specialty Drugs – Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

Step Therapy – Step Therapy is a program which requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs.

Other Plan Information

Claims Inquiry

If you believe a claim was incorrectly denied or you have questions about a prescription, call CVS Caremark Customer Care toll free at (877) 876-7214. TDD: (800) 238-0756.

Health and Prescription Information

Health and prescription information about members is used by CVS Caremark to administer benefits. As part of the administration, CVS Caremark may report health and prescription information to the administrator or sponsor of the benefit plan. CVS Caremark also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

PART 3

MENTAL HEALTH, SUBSTANCE ABUSE AND ENROLLEE ASSISTANCE PROGRAMS

Description of Benefits

Administered by

BEACON

Mental Health, Substance Abuse and Enrollee Assistance Programs

Part I – How to Use this Plan

A Comprehensive Plan Designed with Your Well-Being in Mind

As a *member* of this plan, you are automatically enrolled in the mental health and substance abuse benefits program, as well as the Enrollee Assistance Program (EAP), administered by Beacon Health Strategies (Beacon). Operational since October 1, 1996, Beacon offers easy access to a wide variety of services ranging from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, childcare and eldercare referrals) to acute mental health and substance abuse needs. Beacon's comprehensive continuum of care ranges from inpatient acute care to intensive and traditional outpatient services. Beacon's member-driven and provider-centric approach promotes "the right care, in the right setting, for the right amount of time," and is designed to improve the well-being and functioning of our *members* as quickly as possible. Our primary goal is to offer you and your family high quality services by a network of skilled providers.

Let Us Show You the Benefits

The following section describes your EAP, mental health, and substance abuse benefits offered by Beacon. Please review these carefully before you seek care to ensure that you receive optimal behavioral health benefits. The chart on pages 104-105 provides a brief overview of your benefits; however, it is not a detailed description. The detailed description of your benefits is found in Part III on pages 106-114. Words in italics throughout this description are defined in the "Definitions" section in Part II.

How to Ensure Optimal Benefits

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

Step 1: **Call Beacon for referral information and *pre-certification* for ALL services before you seek EAP, mental health, or substance abuse services; and**

Step 2: **Use a provider or facility that is part of the Beacon network.**

Beacon offers you a comprehensive network of resources and experienced providers from which to obtain EAP, mental health and substance abuse services. All Beacon *network providers* have met Beacon's rigorous credentialing process to provide you with the highest quality care.

If you receive care from a provider or facility that is not part of Beacon's network, your benefit level will be lower than the *in-network* level. Reduced benefits are defined as *out-of-network benefits*. If you do not call Beacon [1-855-750-8980 (TDD: 1-866-727-9441)] to *pre-certify* all services and obtain referral information for your care, your benefits may be reduced. In some cases if you fail to *pre-certify* your care, no benefits will be paid. Please refer to Part III, "Benefits Explained," on

Words in italics are defined in Part II.

pages 106-114, for a full description of your *in-network* and *out-of-network* benefits, as well as special *pre-certification* requirements for *out-of-network* outpatient services. **Benefits will be denied if your care is considered not to be a *covered service*.**

Before You Use Your Benefits

Referral/Pre-certification for Non-Routine Services

To receive EAP services, or before you begin mental health and substance abuse care, contact Beacon at 1-855-750-8980 (TDD 1-866-727-9441).

A qualified Beacon clinician will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or an *in-network provider*. A Beacon clinician is always available to assist you, whether for a routine matter or if you are in need of urgent care. For specific benefits or claims questions, call a customer service representative from 8 a.m. to 7 p.m., Eastern Time (ET) at 1-855-750-8980 (TDD: 1-866-727-9441).[1]

Based on your individual needs, a Beacon clinician will verify whether you are eligible for coverage at the time of your call, and provide you with the names of several mental health, substance abuse or EAP providers who match your specific request (e.g., provider location, gender, or fluency in a second language). A Beacon clinician can also provide you with a referral for legal, financial, dependent care assistance or community resources through your EAP, depending on your specific needs.

A Beacon clinician will *pre-certify* EAP services, *non-routine* outpatient services, and inpatient care requests. Beacon maintains an extensive provider "look-up" database that allows you to search for *in-network* providers. After *pre-certification*, you can then call the provider directly to schedule an appointment.

Emergency Care

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to himself or herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. Beacon will not deny emergency care, but you, a family member or your provider must call Beacon **within 24 hours** of an emergency admission to notify Beacon of the admission. Although a representative may call on your behalf, it is always the *member*'s responsibility to make certain that Beacon has been notified of an emergent admission. If Beacon is not notified of an emergent admission, then a *member* may not be eligible for optimal benefits, or claims may be denied.

Urgent Care

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, our providers will have an appointment to see you within 24 hours of your initial call to Beacon. **If you need assistance scheduling an appointment with an *in-network provider*, a Beacon clinician can assist you.**

1 As part of the Beacon Health Strategies quality control program, supervisors monitor random calls to Beacon's customer services department.

Words in italics are defined in Part II.

Routine Care

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, *in-network providers* will have appointments to see you within three days of your initial call to Beacon. **If you need assistance finding an *in-network* provider with appointment availability, a Beacon clinician can assist you.**

Enrollee Assistance Program (EAP)

Your EAP benefit provides access to a range of resources, as well as confidential, short-term counseling to help you and your dependents manage problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g., international events, community trauma). You must call Beacon to *pre-certify* all EAP services.

Confidentiality

When you use your EAP, mental health and substance abuse benefits under this plan, you are consenting to the release of necessary clinical records to Beacon for *case management* and benefit administration purposes. Information from your clinical records will be provided to Beacon only to the minimum extent necessary to administer and manage the care provided when you use your EAP, mental health and substance abuse benefits, and in accordance with state and federal laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified when you use your EAP, mental health and substance abuse benefits. Beacon staff must comply with a strict confidentiality policy.

Complaints

If you are not satisfied with any aspect of the Beacon program, we encourage you to call Beacon at 1-855-750-8980 (TDD: 1-866-727-9441) to speak with a customer service representative. The Beacon member services representative resolves most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at Beacon, including clinicians, claims representatives, administrators, and other management staff who report directly to senior corporate officers. Beacon will respond to all inquiries within three business days. Your comments will help Beacon correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal *complaint* in writing within 60 days of the date of our telephone call or letter of response. Please specify dates of service and additional contact with Beacon and include any information you feel is relevant. Formal *complaints* will be responded to in writing within 30 days. A formal *complaint* should be sent to:

Ombudsperson
Beacon Health Strategies
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801

Words in italics are defined in Part II.

Appeals

Your Right to an Internal Appeal

You, your treating provider or someone acting on your behalf has the right to request an *appeal* of the benefit decision made by Beacon. You may request an *appeal* in writing by following the steps below.

NOTE: If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase the risk to your health or affect your ability to regain maximum function), please see the section titled "How to Initiate an Urgently Needed Determination (Urgent Appeal)" on page 98.

How to Initiate a First Level Internal Appeal (Non-Urgent Appeal)

Your *appeal* request must be submitted to Beacon within 180 calendar days of your receipt of the notice of the coverage denial.

Written requests should be submitted to the following address:

Beacon Health Strategies
Appeals Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801
Toll-Free Telephone: 1-855-750-8980
Fax Number: 1-781-994-7636

Appeal requests must include:

- The *member's* name and identification number
- The date(s) of service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any documentation or other written information to support your request for claim payment

The Appeal Review Process (Non-Urgent Appeal)

- If you request an *appeal* review, the review will be conducted by someone who was not involved in the initial coverage denial, and who is not a subordinate to the person who issued the initial coverage denial.
- For a non-urgent review of a denial of coverage, a *Beacon clinician* will review the denial decision and will notify you of the decision in writing within 15 calendar days of your request.
- For a review of a denial of coverage that already has been provided to you, Beacon will review the denial and will notify you in writing of Beacon's decision within 30 calendar days of your request.
- If Beacon exceeds the time requirements for making a determination and providing notice of the decision, you may bypass the Beacon internal review process and request a review by an independent third party.
- If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization, who will review your case and make a final decision. This process is outlined in the "Independent External Review Process (Non-Urgent Appeal)" section that follows.

Words in italics are defined in Part II.

Independent External Review Process (Non-Urgent Appeal)

You have a right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

Requests can be made by you, your provider or someone you consent to act for you (your authorized representative). Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Strategies
Appeals Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801
Toll-Free Telephone: 1-855-750-8980
Fax Number: 1-781-994-7636

Independent External Review requests must include:

- Your name and identification number
- The dates of service that were denied
- Your provider's name
- Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or any other relevant information you believe supports your appeal

If you request an independent external review, Beacon will complete a preliminary review within five business days to determine if your request is complete and is eligible for an independent external review.

Additional information about this process along with your member rights and appeal information is available at www.beaconhs.com/gic (if prompted, type in access code GIC), or by speaking with a Beacon representative.

How to Initiate an Urgently Needed Determination (Urgent Appeal)

Generally, an urgent situation is one in which your health may be in serious jeopardy or, if in the opinion of your physician, a delay in making a treatment decision could significantly increase the risk to your health, or affect your ability to regain maximum function. If you believe your situation is urgent, contact Beacon immediately to request an urgent review. If your situation meets the definition of urgent as described above, the review will be conducted on an expedited basis.

If you are requesting an urgent review, you may also request that a separate urgent review be conducted at the same time by an independent third party. You, your provider or someone you consent to act for you (your authorized representative) may request a review. Contact Beacon if you would like to name an authorized representative on your behalf to request a review of the decision.

For an urgent review, Beacon will make a determination and will notify you verbally as well as in writing within 72 hours of your request. If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization, which will review your case and make a final decision. This process is outlined in the "Independent External Review Process (Urgent Appeal)" section that follows.

Words in italics are defined in Part II.

Independent External Review Process (Urgent Appeal)

You have a right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

Requests can be made by you, your provider or someone you consent to act for you (your authorized representative). Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Strategies
Appeals Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801
Toll-Free Telephone: 1-855-750-8980
Fax Number: 1-781-994-7636

Independent External Review requests must include:

- Your name and identification number
- The dates of service that were denied
- Your provider's name
- Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or any other relevant information you believe supports your appeal

If you request an independent external review, Beacon will complete a preliminary review within three business days to determine if your request is complete and is eligible for an independent external review.

Additional information about this process along with your member rights and appeal information is available at www.beaconhs.com/gic (if prompted, type in access code GIC), or by speaking with a Beacon representative.

Filing Claims

In-network providers and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

Out-of-network providers are not required to process claims on your behalf; you may have to submit the claims yourself. You are responsible for all *coinsurance, deductibles* and *copayments*. If you are required to submit the claim yourself, send the *out-of-network provider's* itemized bill and a completed CMS 1500 claim form, with your name, address, and GIC ID number to:

Beacon Health Strategies
500 Unicorn Park Drive
Suite 401
Woburn, MA 01801

Words in italics are defined in Part II.

The CMS 1500 form is available from your provider or on Beacon's website, www.beaconhs.com/gic (if prompted, type in access code GIC). Claims must be received by Beacon within 24 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care and the treatment must be medically necessary. All claims are confidential.

Coordination of Benefits

All benefits under this plan are subject to *coordination of benefits*, which determines whether your mental health and substance abuse care is partially or fully covered by another plan. Beacon may request information from you about other health insurance coverage in order to process your claim correctly.

For More Information

Beacon customer service staff is available to help you. Call 1-855-750-8980 (TDD: 1-866-727-9441) for assistance Monday through Friday, from 8 a.m. to 7 p.m. Eastern Time (ET).

Words in italics are defined in Part II.

Part II – Benefit Highlights

Definitions of Beacon Health Strategies Terms

Allowed Charges – The amount that Beacon determines to be within the range of payments most often made to similar providers for the same service or supply. If the cost of treatment for *out-of-network* care exceeds the *allowed charges*, the *member* may be responsible for the cost difference.

Appeal – A formal request for Beacon to reconsider any adverse determination or denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures or services.

Beacon Clinician – A licensed master's level or registered nurse behavioral health clinician who *pre-certifies* EAP, mental health and substance abuse services. Beacon clinicians have three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

Case Management – A Beacon clinical case manager will review cases using objective and evidenced-based clinical criteria to determine the appropriate treatment that is a covered benefit for a covered diagnostic condition.

Coinsurance – The amount you pay for certain services under Beacon. The amount of *coinsurance* is a percentage of the total cost for the service; the remaining percentage is paid by Beacon. The provider is responsible for billing the *member* for the remaining percentage.

Complaint – A verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision or policy by Beacon.

Continuing review or concurrent review – A clinical case manager will work closely with your provider to determine the appropriateness of continued care, the review of the current treatment plan and progress, and to discuss the member's future care needs

Coordination of Benefits (COB) – A methodology that determines the order and proportion of insurance payment when a member has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the primary plan.

Copayment (copay) – A fixed dollar amount that a *member* must pay out of his or her own pocket.

Covered Services – Services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance use disorder, and that are described in the section titled "What This Plan Pays," and not excluded under the section titled "What's Not Covered – Exclusions."

Cross-Accumulation – The sum of applicable behavioral health expenses paid by a member to determine whether a member's *deductible* has been reached.

Deductible – The designated amount that a *member* must pay for any charges before insurance coverage applies.

Words in italics are defined in Part II.

Intermediate Care – Care that is more intensive than traditional outpatient services but less intensive than 24-hour hospitalization. Some examples include, but are not limited to: partial hospitalization programs, intensive outpatient, and residential detoxification.

Inpatient Care – Acute treatment in a hospital or licensed substance abuse facility.

In-network Provider – A provider who participates in the Beacon network.

Member – An individual who is enrolled in the Group Insurance Commission's UniCare Medicare Extension (OME) plan.

Non-Routine – A service that is not customary. The following services are considered *non-routine* and require *pre-certification*:

- Intensive outpatient treatment programs
- Outpatient electroconvulsive treatment (ECT)
- Psychological and neuropsychological testing
- Applied Behavioral Analysis (ABA)

Out-of-Network Provider – A provider who does not participate in the Beacon network.

Out-of-Pocket Maximum – The maximum amount you will pay in *coinsurance*, *deductibles* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum*, all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include charges for *out-of-network* care that exceed the maximum number of covered days or visits, charges for care not deemed to be a covered service, and charges in excess of Beacon *allowed charges*.

Pre-certification (Pre-certify) – The process of contacting Beacon prior to seeking Enrollee Assistance Program (EAP), mental health and substance abuse care. All *pre-certification* is performed by Beacon clinicians.

Routine Services – A customary or regular service, such as: individual sessions, group therapy of 45 to 50 minutes in duration, and medication management.

Words in italics are defined in Part II.

What This Plan Pays

When medically necessary, the Plan pays for the following services:

- **Outpatient Care** – Individual or group sessions with a therapist conducted in the provider's office or facility, or when appropriate, in a member's home.
- **Intermediate Care** – Care that is more intensive than traditional outpatient services but less intensive than 24-hour hospitalization. Some examples include, but are not limited to: partial hospitalization programs, intensive outpatient and residential detoxification.
- **Inpatient Care** – Acute treatment in a hospital or licensed substance abuse facility.
- **Detoxification** – Medically supervised withdrawal from an addictive chemical substance, which may be done in a licensed substance abuse facility.
- **Drug Screening** – Drug screening is covered as an adjunct to substance abuse treatment when provided in-network. (Excludes screening that is conducted as part of the member's participation in methadone treatment as that is billed as part of the methadone services)
- **Autism Spectrum Disorders** – Services provided for the diagnosis and treatment of autism spectrum disorders pursuant to the requirements of your plan and to the extent of the requirements of Massachusetts law.

The Plan also covers:

- **Enrollee Assistance Program** – Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.beaconhs.com/gic** – An interactive web site offering a large collection of wellness articles, service databases including a Beacon Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to www.beaconhs.com/gic**.** (If prompted, type in access code GIC).

These services are subject to certain Exclusions, which are found in Part III.

Words in italics are defined in Part II.

Benefits Chart

The following chart summarizes certain benefits available to you. Be sure to read Part III which describes your benefits in detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *pre-certify* your care with Beacon Health Strategies before you begin treatment. For assistance, call 24 hours a day, seven days a week: 1-855-750-8980 (TDD: 1-866-727-9441).

Table 9. Mental Health, Substance Abuse and EAP Benefits

Covered Services	Network Benefits	Out-of-Network Benefits (h)
Calendar Year *Deductible* (a,b)	None	$100 per person
Out-of-Pocket Maximum (a)	$1,000 per person	$3,000 per person
Benefit Maximums	Unlimited	Unlimited
Inpatient Care		
Mental Health General Hospital Psychiatric Hospital **Substance Abuse** General Hospital or Substance Abuse Facility	100%, after $50 inpatient care *copayment* per calendar quarter (a,c) 100%, after $50 inpatient care *copayment* per calendar quarter (a,c)	80%, after $150 per admission *copayment* and meeting calendar year *deductible* 80%, after $150 per admission *copayment* and meeting calendar year *deductible*
Intermediate Care (d) Including, but not limited to, 24-hour intermediate care facilities, e.g., crisis stabilization, day/partial hospitals, structured outpatient treatment programs	100% coverage, after $50 inpatient care *copayment* per calendar quarter (a,c)	80%, after $150 per admission *copayment* and meeting calendar year *deductible*
	Note: All intermediate and hospital care must be *pre-certified*. For an emergent admission, you or your provider must notify Beacon within 24 hours to receive maximum benefits.	
Outpatient Care (e,f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)		
Enrollee Assistance Program (EAP) Including, but not limited to: depression, marital issues, family problems, alcohol and drug abuse, and grief. Also includes referral services – legal, financial, family mediation, and elder care.	Up to 4 visits: 100% coverage per member, per calendar year	No coverage for EAP
	Note: *Non-notification penalty* for EAP services reduces benefit to zero: no benefits paid.	

Words in italics are defined in Part II.

Table 9. Mental Health, Substance Abuse and EAP Benefits *(continued)*

Covered Services	Network Benefits	Out-of-Network Benefits (h)
Outpatient Care (e,f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)		
Individual and Family Therapy; to include Autism Spectrum Disorder services	First 4 visits: 100% Visits 5 and over: 100% after $10 *copayment* (d)	First 15 visits: 80% of allowed amount per visit Visits 16 and over: 50% of allowed amount per visit (applies after meeting calendar year *deductible*)
Group Therapy, all types; to include Autism Spectrum Disorder services	First 4 visits: 100% Visits 5 and over: 100% after $5 *copayment* (d)	First 15 visits: 80% of allowed amount per visit Visits 16 and over: 50% of allowed amount per visit (applies after meeting calendar year *deductible*)
Medication Management (15-30 minute psychiatrist visit)	First 4 visits: 100% Visits 5 and over: 100% after $5 *copayment* (d)	First 15 visits: 80% of allowed amount per visit Visits 16 and over: 50% of allowed amount per visit (applies after meeting calendar year *deductible*)
Drug Screening (as an adjunct to substance abuse treatment)	100% coverage	No coverage
Provider Eligibility (provider must be licensed in one of these disciplines)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, BCBA, RNMSCS, MA (g)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, LMHC, LMFT, BCBA, RNCS, MA (g)

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *In-network* and *out-of-network out-of-pocket maximums* do not *cross-accumulate*.

(b) *Cross-accumulates* with all *out-of-network* mental health and substance abuse benefit levels.

(c) Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.

(d) *In-network* outpatient treatment that is not *pre-certified* receives *out-of-network* level of reimbursement.

(e) All *out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.

(f) *Pre-certification* is required for *out-of-network* outpatient non-routine visits. Non-routine outpatient services include, but are not limited to Autism Spectrum Services, psychological testing, neuropsychological testing and EAP.

(g) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, licensed mental health counselors, licensed marriage and family therapist, psychiatric nurse clinical specialists, board-certified behavioral analysts and allied mental health professionals.

(h) *Out-of-network* care is subject to *deductibles*, *copayments* and *coinsurance*.

Benefits are paid based on *allowed charges*, which are Beacon's reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Please note: the words in italics have special meanings that are given in the Glossary section.

Words in italics are defined in Part II.

Part III – Benefits Explained

Mental Health and Substance Abuse Benefits

In-Network Services

In order to receive maximum network benefits for EAP, mental health, and substance abuse treatment you must call Beacon at 1-855-750-8980 (TDD: 1-866-727-9441) to obtain a referral to an *in-network* provider and *pre-certify* care.

In-network care has no *deductible*. *Covered services* are paid at 100% after the appropriate *copayments* (see *copayment* schedule below). The calendar year *out-of-pocket maximum* for *in-network* services is $1,000 per individual. Only *in-network copayments* apply to the *out-of-pocket maximum*.

The following do not count toward the *out-of-pocket maximum*:

- Cost of treatment subject to exclusions

In-Network Benefits

Outpatient Care – The *copayment* schedule for *in-network* outpatient *covered services* is shown below:

Table 10. Copayments for In-Network Outpatient Services

Service	Copayment
Visits 1-4 (Individual, family, Autism Spectrum Disorder, medication management and group)	No *copayment*
Individual and Family Therapy, Autism Spectrum Disorder outpatient visit, visits 5 and over	$10 *copayment*
Medication Management, visits 5 and over	$5 *copayment*
Group Therapy, Autism Spectrum Disorder Group Therapy, visits 5 and over	$5 *copayment*

Failure to *pre-certify non-routine* outpatient care may result in no coverage. Only *routine services* (listed below) do not require *pre-certification*.

Routine Services – Individual sessions, group therapy of 45 to 50 minutes in duration, and medication management are considered *routine services*.

Non-Routine – The following services are considered *non-routine* and require *pre-certification*: Intensive Outpatient Treatment Programs, Outpatient Electroconvulsive Treatment (ECT), psychological testing, neuropsychological testing, and Applied Behavioral Analysis (ABA).

Intermediate Care – *In-network intermediate care* deemed to be a *covered service* in a general or psychiatric hospital or in a substance abuse facility, when *pre-certified*, is covered at 100% after $50 *copayment* per calendar quarter. The *copayment* is waived if readmitted within 30 days, with a maximum of one *copayment* per calendar quarter. Failure to pre-certify intermediate care may result in no coverage.

Words in italics are defined in Part II.

Inpatient Care – *In-network* inpatient care deemed to be a *covered service* in a general or psychiatric hospital, or substance abuse facility, if *pre-certified*, is covered at 100% after a $50 per calendar quarter *copayment*. The *copayment* is waived if readmitted within 30 days with a maximum of one *copayment* per calendar quarter. Failure to pre-certify inpatient care may result in no coverage.

Drug Screening – Drug screening is covered when medically necessary as an adjunct to substance abuse treatment when provided in-network. (Excludes screening that is conducted as part of the member's participation in methadone treatment as that is billed as part of the methadone services)

Autism Spectrum Disorders – The plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders pursuant to the requirements of the plan and to the extent of the requirements of Massachusetts law, including without limitation:

- Professional services by providers – including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board-certified behavior analysts.
- Habilitative and rehabilitative care, including, but not limited to, applied behavioral analysis by a board-certified behavior analyst as defined by law.

Applied Behavioral Analysis Services (ABA) – Coverage for services related to ABA (listed below) are based on medical necessity and managed under Beacon coverage determination guidelines and must be provided by, or under the direction of, an experienced psychiatrist and/or an experienced licensed psychiatric provider or conjoint supervision of paraprofessionals by a BCBA (or qualified licensed clinician) and include the following:

- Skills assessment by BCBA or qualified licensed clinician
- Conjoint supervision of paraprofessionals by BCBA (or qualified licensed clinician) with clients present
- Treatment planning conducted by a BCBA (or qualified licensed clinician)
- Direct ABA services by a BCBA or licensed clinician
- Direct ABA services by a paraprofessional or BCBA (if appropriately supervised)

ABA services must be *pre-certified*. Treatment that is not *pre-certified* may not be covered. Treatment deemed not a *covered service* will result in no coverage.

Psychiatric Services – Psychiatric services for autism spectrum disorders that are provided by, or under the direction of, an experienced psychiatrist and/or an experienced licensed psychiatric provider and are focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning, include:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medication management
- Inpatient/24-hour supervisory care
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment
- Services at a Residential Treatment Facility

Words in italics are defined in Part II.

- Individual, family, therapeutic group, and provider-based case management services
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family
- Crisis Intervention
- Transitional Care

Psychological Testing – Psychological testing, including neuropsychological testing for a mental health condition that is deemed to be a *covered service* is covered when *pre-certified*. Psychological testing that is not *pre-certified* may not be covered. You must obtain *pre-certification* before initiating psychological testing in order to confirm the extent of your coverage.

Enrollee Assistance Program (EAP)

The **EAP** can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a stepparent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or eldercare needs
- Aging
- Traumatic events

To use your EAP benefit, call 1-855-750-8980 (TDD: 1-866-727-9441). The procedures for *pre-certifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by a *Beacon clinician* to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The *Beacon clinician* may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

EAP Counseling Visits – As part of your EAP benefit, you have access to up to four EAP counseling visits per member, per year, with an in-network licensed provider. EAP counseling visits can help with problems affecting work/life balance or daily living, such as marital problems, stress at work, or difficulties adjusting to life changes. These visits are covered at 100%. You can contact Beacon at 1-855-750-8980 with any questions, to receive referrals and to pre-certify visits.

Words in italics are defined in Part II.

Legal Services – In addition to EAP counseling, legal assistance is available to enrollees of the UniCare State Indemnity Plan. Beacon Health Strategies' Legal Assistance services through Beacon's EAP give you free and discounted confidential access to a local attorney, who will answer legal questions, prepare legal documents, and help solve legal issues. The services provide:

- Free referral to a local attorney
- Free 30-minute consultation (phone or in-person) per legal matter
- 25% discount for ongoing services
- Free online legal information, including common forms and will kits

Financial Counseling and Planning – Financial counseling and planning services are also available through the EAP. The financial counseling benefit includes a 30 minute initial telephonic consultation with a financial counselor for assistance with issues such as credit repair, debt management and budgeting. The financial planning benefit includes a 30 minute initial consultation with a financial planner and 15% off of their rate for a Financial Plan Preparation.

Child/Elder Care Referral Service – Through Beacon's EAP, you can access assistance in locating a childcare of eldercare provider that meets your needs. You will receive a packet that contains informational literature, links to federal and private agencies and a list of independent referrals in their area. There is no cost to this referral service.

Domestic Violence Resources and Assistance – This EAP benefit includes access to a confidential, toll-free hotline available 24/7 that provides crisis intervention, safety planning, supportive listening and connection to appropriate resources. Beacon can also provide referrals to a wide range of supportive services for members experiencing domestic violence, including specialized counseling, temporary emergency housing, and legal assistance.

Employee Assistance Program for Agency Managers and Supervisors – The Commonwealth's Group Insurance Commission also offers an Employee Assistance Program to all managers and supervisors of agencies and municipalities. Managers and supervisors can receive critical incident response, confidential consultations and resource recommendations for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness, and substance abuse. Managers and supervisors can also access trainings for their teams on topics such as stress management and coping with challenging behaviors.

Out-of-Network Services

Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*. Benefits are paid based on *allowed charges* that are Beacon reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health and substance abuse treatment is subject to a $100 per person calendar year *deductible*. Calendar year *deductibles* must be met prior to inpatient *copayments* and *cross-accumulates* between all *out-of-network* mental health and substance abuse benefit levels.

Out-Of-Pocket Maximum – A $3,000 individual *out-of-pocket maximum* applies to you each calendar year for *covered services* you receive at the *out-of-network* level of benefits.

Words in italics are defined in Part II.

The only charges that satisfy this *out-of-pocket maximum* are the *deductible*, *copayments*, and *coinsurance* for *covered services* obtained at the *out-of-network* level of benefits. Once you satisfy the individual *out-of-pocket maximum* in a calendar year, all *covered services* you receive at the *out-of-network* level of benefits are covered at 100% of the *allowed charges* until the end of that calendar year.

Important: Once you have met your *out-of-pocket maximum* in a calendar year, you continue to pay for any costs in excess of *allowed charges*.

You cannot use the following to satisfy this *out-of-pocket maximum*:

- Charges for *out-of-network* care that exceeds the maximum number of days or visits
- Charges for care not deemed to be a *covered service*
- Charges in excess of Beacon *allowed charges*

All *out-of-network* care must be *pre-certified* with Beacon in order to obtain maximum coverage. All *out-of-network* outpatient visits in a calendar year, including mental health, substance abuse and medication management visits, and in-home mental health care visits, are accumulated to determine the appropriate *out-of-network* level of reimbursement. There are different levels of reimbursement for *out-of-network* outpatient visits 1-15 and visits 16 and over, as described below. Also, all *out-of-network* outpatient visits are subject to the same *pre-certification* requirements as *in-network* benefits in order to be eligible for coverage. Charges paid by the covered person for *out-of-network* outpatient care, if determined to be a *covered service* and if *pre-certified* when required, do count toward the *out-of-pocket maximum*. If it is determined that care was not a *covered service*, no benefits will be paid.

Out-of-Network Benefits

Outpatient Care – *Out-of-network* outpatient visits 1-15 deemed to be a *covered service* are paid at 80% of Beacon's *allowed charges*, after your $100 calendar year *deductible* is met. Out-of-network outpatient visits after visit 15 are paid at 50% of Beacon's *allowed charges* if deemed to be a *covered service*. Charges paid by the covered person for outpatient *out-of-network* care in excess of Beacon's *allowed charges* do not count towards the *out-of-pocket maximum*.

Intermediate Care – *Out-of-network* intermediate care deemed to be a *covered service* for mental health care or substance abuse treatment is paid at 80% of *allowed charges*, in a general hospital, psychiatric facility, or substance abuse facility.

Each admission to a hospital or facility is subject to $150 inpatient *copayment* per admission in addition to the calendar year *deductible*. To ensure maximum coverage, it is important that you or your provider has *pre-certified* your care. No benefits will be paid if it was found not to be a *covered service* or not medically necessary.

Inpatient Care – *Out-of-network* inpatient care deemed to be a *covered service* for mental health care or substance abuse treatment is paid at 80% of *allowed charges*, in a general hospital, psychiatric facility, or substance abuse facility.

Each admission to a hospital or facility is subject to $150 inpatient *copayment* per admission in addition to the calendar year *deductible*. To ensure maximum coverage, it is important that your or your provider has *pre-certified* your care. No benefits will be paid if it was found not to be a *covered service* or not medically necessary.

Words in italics are defined in Part II.

Drug Screening – There is no coverage for *out-of-network* drug screening.

Autism Spectrum Disorders – The plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders, pursuant to the requirements of the plan and to the extent of the requirements of Massachusetts law, including without limitation:

- Professional services by providers – including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board-certified behavior analysts.
- Habilitative and rehabilitative care, including, but not limited to, applied behavioral analysis by a board-certified behavior analyst as defined by law.

Applied Behavioral Analysis Services (ABA) – Coverage for services related to ABA (listed below) are based on medical necessity and managed under Beacon's coverage determination guidelines and must be provided by, or under the direction of, an experienced psychiatrist and/or an experienced licensed psychiatric provider or conjoint supervision of paraprofessionals by a BCBA (or qualified licensed clinician) and include the following:

- Skills assessment by BCBA or qualified licensed clinician
- Conjoint supervision of paraprofessionals by BCBA (or qualified licensed clinician) with clients present
- Treatment planning conducted by a BCBA (or qualified licensed clinician)
- Direct ABA services by a BCBA or licensed clinician
- Direct ABA services by a paraprofessional or BCBA (if appropriately supervised)

ABA services must be *pre-certified*. Treatment that is not *pre-certified* may result in no coverage.

Psychiatric Services – Psychiatric services for autism spectrum disorders that are provided by, or under the direction of, an experienced psychiatrist and/or an experienced licensed psychiatric provider and are focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning, include:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medication management
- Inpatient/24-hour supervisory care
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment
- Services at a Residential Treatment Facility
- Individual, family, therapeutic group, and provider-based case management services
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family
- Crisis Intervention
- Transitional Care

Enrollee Assistance Program (EAP) – There is no coverage for *out-of-network* EAP services.

Words in italics are defined in Part II.

Psychological Testing – *Out-of-network* psychological testing, including neuropsychological testing for a mental health condition that is deemed to be a *covered service*, is covered when *pre-certified*. Psychological testing, including neuropsychological testing, that is not *pre-certified* will result in no coverage. You must obtain *pre-certification* before initiating psychological testing in order to confirm the extent of your coverage. Please note that neuropsychological testing for a medical condition is covered under the medical component of your plan.

What's Not Covered – Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the covered person's provider and/or are the only available treatment options for the covered person's condition.

This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM)
- Prescription drugs or over-the-counter drugs and treatments. (Refer to your prescription drug plan for benefit information.)
- Services or supplies for mental health/substance abuse treatment that, in the reasonable judgment of Beacon, are any of the following:
  - Is not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse
  - Is not consistent with prevailing national standards of clinical practice for the treatment of such conditions
  - Is not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome
  - Typically does not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with the Beacon level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time

  Beacon may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.
- Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a *covered service* if the service, treatment, or device is considered to be unproven, investigational, or experimental.

Words in italics are defined in Part II.

- Custodial care except for the acute stabilization of the covered person and returning the covered person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  - It provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to ensure the covered person's competent functioning in activities of daily living; or
  - It is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the covered person to function outside a structured environment. This applies to covered persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Neuropsychological testing for the diagnosis of attention-deficit hyperactivity disorder. (Note: Neuropsychological testing for medical conditions is covered under the medical component of your plan.)
- Examinations or treatment, unless it otherwise qualifies as behavioral health services, when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; or
  - Ordered by a court except as required by law; or
  - Conducted for purposes of medical research; or
  - Required to obtain or maintain a license of any type
- Herbal medicine, or holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs, special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.

Words in italics are defined in Part II.

- Travel or transportation expenses unless Beacon has requested and arranged for covered person to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as the covered person.
- Behavioral health services for which the covered person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services provided under another plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for covered person because covered person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or coverage under a similar law had that coverage been elected.
- Behavioral health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when covered person is legally entitled to other coverage.
- Treatment or services received prior to covered person being eligible for coverage under the Plan or after the date the covered person's coverage under the Plan ends.

Words in italics are defined in Part II.

APPENDICES

Appendix A: GIC Notices

Appendix B: Disclosure when Plan Meets Minimum Standards (for health insurance coverage in Massachusetts)

Appendix C: Forms

Appendix D: Federal and State Mandates

Appendix E: Preventive Care Schedule

Appendix F: Preferred Vendors

Appendix A: GIC Notices

- Notice of Group Insurance Commission (GIC) Privacy Practices
- Important Notice from the Group Insurance Commission (GIC) about Your Prescription Drug Coverage and Medicare
- Important Information from the Group Insurance Commission about Your HIPAA Portability Rights
- The Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Notice about the Federal Early Retiree Reinsurance Program

Notice of Group Insurance Commission (GIC) Privacy Practices

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities

The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations

The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products

Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013.

Other Permitted Uses and Disclosures
The GIC may use and share PHI as follows:

- To resolve complaints or inquiries made by you or on your behalf (such as appeals);
- To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- For data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- To verify agency and plan performance (such as audits);
- To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- For judicial and administrative proceedings (such as in response to a court order);
- For research studies that meet all privacy requirements; and
- To tell you about new or changed benefits and services or health care choices.

Required Disclosures
The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us
In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.

- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at **www.mass.gov/gic**.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

Important Notice from the Group Insurance Commission (GIC) about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DON'T NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

- You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.
- Your GIC drug coverage is part of your GIC health insurance which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan or Tufts Health Plan Medicare Preferred, you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov**, or by phone at (800) 772-1213, or TTY: (800) 325-0778.
- If you do decide to join a Medicare drug plan and drop your current GIC health coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or Your Current Prescription Drug Coverage …

Contact the GIC at (617) 727-2310, ext.1.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage ...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Important Information from the Group Insurance Commission about Your HIPAA Portability Rights

Pre-existing condition exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a specified period of time before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (in some cases, 18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy or genetic information and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Prohibition against discrimination based on a health factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage

Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.
- Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

Notice about the Federal Early Retiree Reinsurance Program

The notice below is a requirement of the federal Patient Protection and Affordable Care Act's Early Retiree Reinsurance Program, for which the Group Insurance Commission (GIC) has applied for reinsurance funds. Although the GIC has received reinsurance funds, it is too early to say exactly how the GIC will allocate such funds. The GIC's expectation is that part of such funding would be used to enhance existing programs, and part could be used to lower members' costs, and to subsidize, in part, member claims costs. You will be informed as to any such programs and benefit enhancements as soon as they are determined.

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the new federal health reform's Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a federal program that was established under the Patient Protection and Affordable Care Act. Under the Early Retiree Reinsurance Program, the federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor **may choose** to use any reimbursements it received from this program to reduce or offset increases in plan participants' premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs. If the plan sponsor **chooses** to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Appendix B: Disclosure when Plan Meets Minimum Standards

*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:
As of January 1, 2008, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets the **Minimum Creditable Coverage standards** that became effective July 1, 2008 as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2014. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Appendix C: Forms

This appendix contains the following forms:

- Fitness Club Reimbursement Form
- Tobacco Cessation Counseling Reimbursement Form

💻 You can download these and other forms, such as claim forms, from www.unicarestateplan.com.

If you don’t have access to a computer, you can request forms by calling UniCare Customer Service at (800) 442-9300.

Fitness Club Reimbursement Form

UniCare®

Please print clearly. Keep a copy of all receipts and documents for your records. Please be sure to sign the form. The reimbursement is paid once each year as a lump sum to the plan enrollee, upon proof of fitness club membership and payment.

1. Name of Enrollee (Last, First, MI)	2. UniCare ID Number	3. Date of Birth

4. Enrollee Address: Phone:	5. Fitness Club Name and Address: Phone:
6. Name of Member (Last, First, MI)	7. Member's Relationship to Enrollee:
8. Proof of membership: ☐ Copy of fitness club membership agreement	9. Amount paid:

10. Proof of payment (check one):

- ☐ Itemized receipt from the fitness club, showing the dates of membership and dollar amounts paid
- ☐ Copies of receipts for fitness club membership dues
- ☐ Credit card statement or receipt
- ☐ Statement from fitness club indicating payment was made (on club letterhead and with authorized signature)

Receipts or statements must include member name, amount charged, amount paid and service dates.

I agree to the information written above, and verify that I met the requirements of the program.

11. Signature (required): _____ Date: _____

The person signing this form is advised that the willful entry of false or fraudulent information renders you liable to be withdrawn from this fitness reimbursement program.

Please send this form and all documentation to:

UniCare State Indemnity Plan – Fitness Club Reimbursement
PO Box 9016
Andover, MA 01810

For Plan Use Only	
12. Procedure code: S9970 – Fitness Club Membership	13. Diagnosis: 799.9
	14. TIN: 000000002

Tobacco Cessation Counseling Reimbursement Form

UniCare®

Please print clearly. Keep a copy of all receipts and documents for your records. Please be sure to sign the form. The reimbursement is paid upon proof of tobacco cessation counseling and payment.

1. Name of Enrollee (Last, First, MI)	2. UniCare ID Number	3. Date of Birth

4. Enrollee Address:	5. Smoking Cessation Provider Name and Address:
Phone:	Phone:
6. Name of Member (Last, First, MI)	7. Member's Relationship to Enrollee:

8. Dates of Service: **From:** **To:**

9. Number of minutes:	10. Amount paid:

11. Proof of participation in program ☐ **Itemized receipt**

Receipt must include member name, dates of service, amount charged and amount paid.

I agree to the information written above, and verify that I met the requirements of the program.

12. Signature (required): **Date:**

The person signing this form is advised that the willful entry of false or fraudulent information renders you liable to be withdrawn from this tobacco cessation counseling reimbursement program.

Please send this form and all documentation to:

UniCare State Indemnity Plan – Tobacco Cessation Counseling Reimbursement
PO Box 9016
Andover, MA 01810

For Plan Use Only		
13. Procedure code: S9453	14. Diagnosis: 305.1	15. TIN: 000000002

Appendix D: Federal and State Mandates

- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Coverage for Reconstructive Breast Surgery
- Minimum Maternity Confinement Benefits

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll free 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. You should contact your state for further information on eligibility.

Premium Assistance Under Medicaid and CHIP

ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov

Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437

Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/

Medicaid Phone (In state): 1-800-866-3513

Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/

Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)

Phone: 1-800-869-1150

IDAHO – Medicaid

Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx

Medicaid Phone: 1-800-926-2588

INDIANA – Medicaid

Website: http://www.in.gov/fssa

Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov

Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-977-6740

TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth

Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance

Phone: 1-800-657-3629

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov

Phone: 1-800-383-4278

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov

Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: https://www.gethipptexas.com/

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Website: http://health.utah.gov/upp

Phone: 1-866-435-7414

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm

Medicaid Phone: 1-800-432-5924

CHIP Website: http://www.famis.org/

CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx

Phone: 1-800-562-3022 ext.15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/

Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: http://www.badgercareplus.org/pubs/p-10095.htm

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://health.wyo.gov/healthcarefin/equalitycare

Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
2323, Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565[1]

Coverage for Reconstructive Breast Surgery

Coverage is provided for reconstructive breast surgery as follows:

1. All stages of breast reconstruction following a mastectomy
2. Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
3. Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. Parent education
2. Assistance and training in breast or bottle feeding, and
3. Performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan within 24 hours – one business day – of being admitted to the hospital. Please call a nurse reviewer at the Andover Service Center if you have questions.

1 OMB Control Number 1210-0137 (expires 10/31/2016)

Appendix E: Preventive Care Schedule

This chart shows the preventive services covered under your health plan. Benefits for the services listed here are covered at 100% subject to the gender, age and frequency guidelines indicated.

Preventive services do not generally include services intended to treat an existing illness, injury, or condition. Benefits will be determined based on how the provider submits the bill. Claims must be submitted with the appropriate diagnosis and procedure code in order to be paid at the 100% benefit level. If during your preventive services visit you receive services to treat an existing illness, injury or condition, you may be required to pay a copay, deductible and/or coinsurance for those covered services.

Please note that the preventive health care services, screenings, tests and vaccines listed are not recommended for everyone. You and your health care provider should decide what care is most appropriate.

Table 11. Preventive Care Schedule

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Abdominal aortic aneurysm screening	■				65-75	One time
Alcohol misuse screening and counseling	■	■	■			Covered as a component of your preventive exam
Anemia screening	■	■	■	■		
Bacteriuria screening			■			
Blood pressure screening	■	■	■			Covered as a component of your preventive exam
Breast cancer screening (mammogram)		■			35 and 40 and older	Once between the ages of 35 and 40; yearly after age 40
Breast cancer preventive medications discussion		■	■			Covered as a component of your preventive exam
BRCA risk assessment and genetic counseling/testing		■	■			One time
Breastfeeding counseling		■	■			
Cervical cancer screening (Pap smear)		■	■	■		Every 12 months
Chlamydial infection screening		■	■	■		
Cholesterol abnormalities screening	■	■	■			Every 12 months

Table 11. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Colorectal cancer, screening (Screenings include: colonoscopy, sigmoidoscopy, procto-sigmoidoscopy, barium enema, fecal occult blood testing, laboratory tests, and related services) Virtual colonoscopy or virtual colonography is not covered (see “Excluded Services”)	■	■			50 and older	Every 5 years (60 months) Every 12 months for fecal occult blood test
Depression screening	■	■	■	■		Covered as a component of your preventive exam
Diabetes (Type 2) screening	■	■	■			
Diet, behavioral counseling in primary care to promote healthy diet, in adults at high risk for cardiovascular disease (see “Limited Services”)	■	■	■			Covered as a component of your preventive exam
Evaluation and management services (E/M) (periodic preventive examination/office visits) for children up to age 19				■		• Two examinations, including hearing screening, while the newborn is in the hospital. • Five visits until 6 months of age; then • Every two months until 18 months of age; then • Every three months from 18 months of age until 3 years of age; then • Every 12 months from 3 years of age until 19 years of age.
Evaluation and management services (E/M) (periodic preventive examination/office visits) for adults age 19 and over	■	■				• Every 36 months (three years) until age 40; then • Every 24 months (two years) between ages 40 and 59; then • Every 12 months (once a year) after age 60.
Gonorrhea screening		■	■			Every 12 months
Gonorrhea, prophylactic medication (newborns)				■		
Gynecological examination		■				Every 12 months

Table 11. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Hearing loss screening (newborns)				■		
Hepatitis B screening			■			
Hepatitis C virus infection screening	■	■	■			One time for adults born between 1945 and 1965
HIV screening	■	■	■	■		
Hypothyrodism screening (newborns)				■		
Immunizations	■	■	■	■		
Intimate partner violence screening (women of childbearing age)		■	■			Covered as a component of your preventive exam
Iron deficiency anemia prevention (at risk 6- to 12-month-old babies)				■		
Lead screening children				■		
Lung cancer screening (CT scan) for adults who have smoked	■	■			55-80 years	Every 12 months
Obesity screening	■	■	■	■		Covered as a component of your preventive exam
Osteoporosis screening (bone density testing)		■			40 and older	Every 2 years
Phenylketonuria (PKU) screening (newborn)				■		
Prostate cancer screening (digital rectal exam and PSA test)	■				50 and older	• Digital exam – Covered as a component of your preventive exam • PSA test – Every 12 months
Rh incompatibility screening			■			
Sexually transmitted infections counseling	■	■	■	■		Covered as a component of your preventive exam
Sickle cell disease screening (newborns)				■		
Skin cancer behavioral counseling	■	■	■	■	10-24 years	Covered as a component of your preventive exam
Syphilis infection screening	■	■	■	■		

Table 11. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Visual impairment screening	■	■	■	■		Covered as a component of your preventive exam
Additional covered screening laboratory tests for adults: • Hemoglobin • Urinalysis • Chemistry profile for the purpose of preventive screening includes the following: – Complete blood count (CBC) – Glucose – Blood urea nitrogen (BUN) – Creatinine transferase alanine amino (SGPT) – Transferase asparate amino (SGOT) – Thyroid stimulating hormone (TSH)	■	■	■			When performed as a component of your preventive exam

Appendix F: Preferred Vendors

Both Medicare and the UniCare State Indemnity Plan offer preferred vendors for certain services. You get the highest level of coverage when you use preferred vendors.

For services that Medicare covers, the preferred vendors are Medicare contract suppliers. To find a Medicare contract supplier, visit **www.medicare.gov/supplier**.

Use one of the preferred vendors listed in this appendix if:

- There is no Medicare contract supplier available in your area, or
- The service you need is not covered by Medicare, but it is covered by UniCare.

For services marked with a **telephone symbol** ☎, you or someone acting for you must call the Andover Service Center at (800) 442-9300 prior to the start of these services to receive the highest level of benefits.

If you have questions about using preferred vendors, contact the Andover Service Center at (800) 442-9300.

Table 12. ☎ Durable Medical Equipment (DME)

- Vendors for therapeutic air flow pressure relief mattresses are listed in Table 14 and vendors for medical supplies are listed in Table 15.
- No notification is required for oxygen and oxygen equipment.

Vendor Name	Contact	Service Details
Apria/Coram Healthcare	(800) 649-2422	Service area: Nationwide Standard DME and respiratory equipment, including but not limited to CPAP and BPAP machines and related supplies
Baystate Home Infusion and Respiratory Services	(800) 497-7114 (413) 794-4663	Service area: Western MA Respiratory equipment only, including but not limited to CPAP and BPAP machines and related supplies
Boston Home Infusion	(800) 364-3306 (781) 326-1986	Service area: MA DME, respiratory therapy and home infusion
Clinical One	(800) 261-5737 (781) 331-6856	Service area: Eastern MA Standard DME and respiratory equipment, including but not limited to CPAP and BPAP machines and related supplies
Coastal Sleep Diagnostics	(800) 229-0087 (781) 740-9155	Sleep studies; respiratory DME equipment, including but not limited to CPAP and BPAP machines and related supplies
EBI, LP	(800) 526-2579	Service area: Nationwide Bone stimulators, medication pumps and dynamic splints

Vendor Name	Contact	Service Details
Hudson Seating & Mobility	(800) 321-4442	Service area: Western MA, CT, NH, NJ, NY, RI DME, excluding respiratory equipment
Independent Mobility	(413) 499-4846 (877) 572-6683	Service area: Western MA, southern VT, Albany, NY Mobility equipment
Inspire Medical (dba Denmarks Home Medical)	(800) 479-5511	Service area: MA Standard DME
KCI	(800) 275-4524	Service area: National Wound-vacuum assisted closures (V.A.C.)
M+M Medical Supply, Inc.	(877) 966-6337	Service area: MA, RI, northeast CT, southern NH Standard DME
National Seating and Mobility	*Inside MA:* (800) 660-0069 *Outside MA:* (877) 482-2602	Service area: Eastern MA, CA, CO, FL, GA, IN, NC, NY, OH, PA, SC, TN, TX, WI Custom DME only
New England Surgical, Inc.	(800) 336-1300	Continuous passive motion only
North Atlantic Medical Supply dba Regional Home Care	(800) 229-6267	Respiratory equipment, including but not limited to CPAP and BPAP machines and related supplies

Table 13. ☎ Home Infusion Therapy

Vendor Name	Contact	Service Details
Apria/Coram Healthcare	(800) 678-3442	
Baystate Home Infusion and Respiratory Services	(800) 497-7114 (413) 794-4663	
Boston Home Infusion	(781) 326-1986	
Home Solutions	*Canton:* (888) 660-1660 *Falmouth:* (800) 244-1227	Service area: Boston Metro, Cape Cod & the Islands
Southcoast Home, Hospice and Home Infusion	(800) 698-6877 (508) 973-3200	

Table 14. ☎ Therapeutic Air Flow Pressure Relief Mattresses

Vendor Name	Contact	Service Details
Hill Rom, Inc.	(800) 638-2546	

Table 15. ☎ Medical Supplies

Vendor Name	Contact	Service Details
Animas Diabetes Care, LLC	(877) 937-7867	Insulin pumps
Byram Healthcare	(877) 902-9726	
Insulet Corporation	(800) 591-3455	OmniPod® Insulin Management System
Medtronic/MiniMed, Inc.	(800) 633-8766	Insulin pumps, diabetic supplies
Neighborhood Diabetes Shoppe	(800) 937-3028	
Sterling Medical Services	(888) 907-8775	Wound, urological, ostomy and diabetic supplies

Table 16. ☎ Home Health Care

Vendor Name	Contact	Service Details
Bayada Home Health Care	(888) 995-0788	
Baystate VNA & Hospice	*Springfield:* (800) 249-8298 *Ware:* (866) 808-0204	
Berkshire VNA	*Pittsfield:* (413) 447-2862 *Great Barrington:* (413) 528-1048	
Centrus Home Care	(800) 698-8200	
Hallmark VNA	(781) 338-7800	
Noble VNA and Hospice	(413) 562-7049 (888) 683-7049	
Partners HealthCare at Home	(781) 290-4200	
South Shore VNA	(781) 624-7070	
Southcoast Home, Hospice and Home Infusion	(800) 698-6877 (508) 973-3200	
Steward Home Care	(888) 820-1640	
VNA Care Network and Hospice	(800) 728-1862	
VNA Hospice Alliance of Cooley Dickinson Hospital	(413) 584-1060	
VNA of Boston	(617) 426-5555	
Wing VNA and Hospice	(413) 283-9715	
VNA of New England	Please call the Andover Service Center at (800) 442-9300 for more information.	

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